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Wisconsin Department of Public Instruction / Barbara Thompson, Ph.D., State Superintendent

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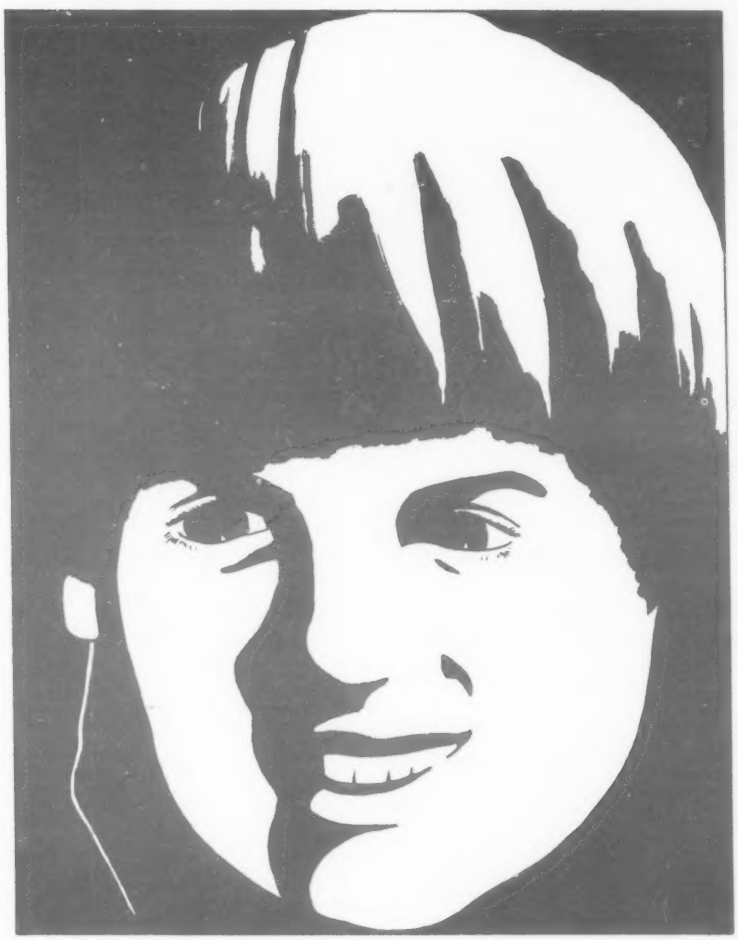

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Guest Editor-Caryl Hatfield is a nursing specialist within the Bureau for Children with Physical Needs, Division for Handicapped Children. This issue deals with medical and nursing concerns for the school-aged child. This issue also contains information about two federally funded projects of interest to exceptional education teachers and administrators—Wisconsin Dissemination Project and the Wisconsin State Facilitator Project.

Guidelines for Authors

The *Bureau Memorandum* invites manuscripts directed to the common interests of special education personnel in schools. Especially welcome is stimulating writing dealing with (1) discussions of current professional and special education related materials; (2) descriptions of new techniques of innovative practices and programs; (3) research reports of interest and significance to readers. Dialogues, poems, and brief descriptions of new practices and programs will also be considered.

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Manuscripts to be considered for publication in any issue of the *Bureau Memorandum* should:

- be submitted in duplicate (original and one clear copy)
- be typewritten (pica style), double spaced. All references, footnotes, and direct quotations should be checked carefully for accuracy.
- be accompanied by a complete identification of all authors. Include title and position, present location, and mailing address of each author.
- if appropriate, include black and white photos that have good light and dark contrast and that are at least 3" x 5."
- manuscripts should average about 1,500 words—approximately six double-spaced typewritten pages.

Manuscript Submission

- send manuscripts to Editors, *Bureau Memorandum,* Division for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.
- acknowledgement of receipt of a manuscript and notification concerning its disposition will be sent to the main author within 3 weeks of arrival. Additional time will elapse between acceptance of the article and its appearance in print.

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School Nursing — A Framework for Practice

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Inspired and challenged by the visions of Jerome Lysaught in "Bell, Book, and Candle: The National Commission and the School Nurse," we are no longer content to sit back passively and await the extinction of school nursing. Declining enrollments, budgetary cutbacks, and the inability of school nurses to articulate and account for their practice have all been cited as factors contributing to the current crisis in school nursing. Of these three reasons, nursing has direct responsibility for the latter. As Lysaught succinctly states ". . . the trouble may not be in our stars, but in ourselves."[1]

The purpose of this article is to facilitate acceptance of this responsibility by providing school nurses with a conceptual framework that can be used to structure their practice.

Conceptual Framework

By Aldous' definition,[2] concepts are useful ideas that ". . . enable man to learn from experience, to identify current events, to behave appropriately, and to study systematically such phenomena. . ." as school nursing. When concepts are organized into a conceptual framework that may be thought of as a cluster of concepts relating to a particular phenomenon, their application to practice is facilitated. The cluster of concepts we have chosen as our framework is schematically represented below:

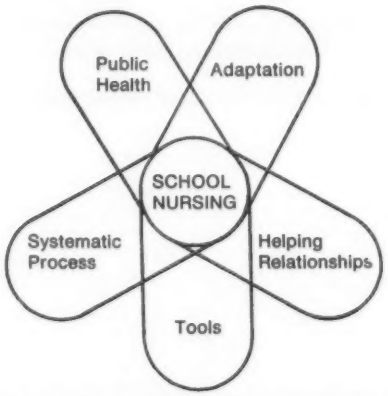

Figure 1 -Conceptual framework model nursing for school.

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Overlapping areas constitute the scope and focus of school nursing.

In discussing each concept, we will provide a definition, a rationale for inclusion, and examples illustrating the applicability to school nursing practice.

Public Health

According to Fredlund,[3] school nursing is a part of *community nursing* and therefore has as its basis an understanding of "public health." In its broadest sense, public health may be thought of as ". . . a continuum of activities to protect the health of the community."[4] These activities are organized into three levels[5] which are as follows: (1) "primary prevention" which includes health promotion and specific protection; (2) "secondary prevention" which includes early diagnosis, prompt treatment, and disability limitation; and (3) "tertiary prevention" which focuses primarily on rehabilitation.

The school nurse specifically focuses on promotion of "high level wellness" which Dunn[6] defines as ". . . an integrated method of functioning which is oriented toward maximizing the potential of which the individual is capable within the environment where he is functioning." It follows logically from this definition that the school nurse's client system should include not only the school child but also his family, school personnel, and the community at large.

The following examples will demonstrate the applicability of public health concepts to the practice of school nursing. At the primary prevention level, an immunization program illustrates both "health promotion" and "specific protection" activities. Successful implementation of any immunization program for school children requires active coordination of the efforts of all involved personnel by the school nurse in planning, implementation, and follow-up, including delegation of appropriate tasks, as depicted in Figure 2.

At the secondary prevention level, the school nurse conducts various screening programs such as vision, hearing, and scoliosis. In each program, the nurse is involved with planning, implementation, and follow-up activities. Although the primary recipient in these screening programs is the child, the family and community are also involved. The nurse initiates contact with the family when deviations are noted and facilitates their referral to existing community re-

Planning Activities	Implementation Activities	Follow-up Activities
- consults with local health dept. officials, school administrators, and community representatives in setting goals, objectives, and means	- works with school administrators and families to identify specific immunization needs of school children	- records immunizations
- promotes successful achievement of goals and objectives through health education with children, families, school personnel, and community	- orders supplies	- reads and records results of tuberculin testing
	- coordinates the clinic: recruits and orients volunteers, sets up clinic routing patterns	- monitors reactions
	- screens commmunity recipients regarding immunization needs and contraindications	- refers clients to other community resources for completion of immunization schedule
	- manages emergency situations	- participates in the evaluation of the program's goals and objectives

Figure 2 -The school-based immunization program: The school nurse as health team coordinator.

sources for necessary follow-up. If no resource is readily available for follow-up, the truly "public health-oriented" school nurse will intervene at the community level to stimulate appropriate agencies or groups to develop a resource.

At the tertiary prevention level, the school nurse works to facilitate the positive adaptation of a handicapped child in the school setting. She coordinates the care of the child with input from school personnel, the family, and the child's primary physician. She provides for special class schedule changes, rest, nutrition, medication, and treatment needs during the school day. She counsels the child, his peers, and school personnel to enhance his acceptance in the school environment. She also advises school personnel regarding necessary modifications of the physical plant such as addition of ramps, handrails, restroom accommodations, etc. To ensure continuity of care between school and home, she makes home visits as needed for assessment, counseling, and emotional support.

Adaptation

Adaptation is a concept that has been used and defined by many authors. For our purposes, the most useful definition is advanced by Byrne and Thompson[7] stating that adaptation is ". . . the positive, constructive end results . . . that occur when adjustments are made to either an internal or external environmental change." Since adaptation focuses on the positive, constructive end results of one's interaction with his environment, it is quite appropriate to use this concept to promote the child's attainment of high level wellness.

Byrne and Thompson[7] suggest that the nurse focus on the orderliness, consistency, and coherency of the child's behaviors as a means of assessing adaptation. Specifically they suggest that the following questions be addressed:

1. What are the limitations with which the child must cope?
2. To what degree is the child utilizing his potential?
3. How does the child view or evaluate his situation?
4. What are the available environmental resources and how can they be utilized more effectively?

In applying this concept to school nursing practice, an appropriate example is that of the diabetic child leaving elementary school and entering junior high school. Because of hourly classroom changes, the child will face expanded peer group influences and varied teacher expectations. In addition to these external environmental changes, the child must cope daily with internal changes resulting from the developmental tasks which confront him as an adolescent. The child's need for a structured diabetic management regime is threatened by these new needs. By using Byrne and Thompson's four questions, the child's past behavior and new needs can be reordered into a new regime compatible with his physical requirements, social needs, and new school environment.

In the above example, it is the responsibility of the school nurse to anticipate and plan for these necessary changes by communicating with the child, his family, involved school personnel, the school nurse from his former school and his physician as needed.

Helping Relationships

Like other helping professions such as medicine, social work, and guidance counseling, nursing is concerned with "people problems." Specifically this requires nursing practitioners to focus on " . . . helping people achieve more effective relationships between themselves and others or the world in which they live."[8] Such a focus is consistent with the adaptation frame of reference discussed above and with our belief that the goal of nursing is the promotion of high level wellness for the client system.

Successful intervention by the school nurse to facilitate attainment of high level wellness by the client system, depends upon the establishment of an effective *helping relationship,* which may be defined as " . . . the effective use of the helper's self in bringing about fulfillment of his own and society's purposes."[8] According to this definition then, the effectiveness of the relationship depends on the nurse's ability to utilize her "self" as an instrument or *tool.* How she does this will further depend on her beliefs about herself as

a person and as a "helper," her beliefs about the child, her beliefs about nursing as a profession, and her beliefs about the nature and purposes of man and society. Although there are many "techniques" which can be learned to assist one in becoming a "helping person," — interviewing and listening techniques, — the establishment of a truly *helping relationship* requires an attitude of the helper which Carl Rogers describes as genuineness or "realness." This simply means that the helper is "being himself" in his encounters with the child and is avoiding any facade which could jeopardize the relationship.

The ability to establish and maintain helping relationships is of obvious importance for the school nurse. Because she is generally viewed as a helping person who, unlike the teachers and administrative personnel in the school, has no direct authority or control over the student's lives, the school nurse can be a trusted adult to assist the child with his problems without fear of reprisal. However, her ability to assess needs, plan interventions, and evaluate the outcome will rely on the establishment of a helping relationship.

A real challenge to the school nurse might be the pregnant adolescent who confides her fears and uncertainties to the nurse. Development of a helping relationship requires first of all that the school nurse be in touch with her own feelings and beliefs regarding unwed pregnancy so that she can be nonjudgmental or "real." Having worked through her feelings about the student's pregnancy, the school nurse should be able to develop rapport and trust so that a realistic contract can be negotiated. This contract might realistically include the psychological support of the student when her family is informed of the pregnancy, referral of the student to appropriate community resources for pregnancy testing and follow-up, facilitation of the student's problem-solving by helping her identify and sort out alternatives, and communication of any decisions to the appropriate school personnel.

Tools

The fourth concept in this framework's cluster is "tools." According to Webster,[10] a "tool" is " . . an instrument or apparatus . . . necessary in the practice of a vocation or profession." Nurses use tools to assess clients' needs, adaptation, and level of wellness. Their tools include nursing history, systematic assessment of functional areas, and nursing diagnosis.[11] The format used for collecting and recording a nursing history or determining a nursing diagnosis will vary according to the educational preparation, professional work experience, and nursing philosophy of the individual practitioner. Systematic assessment of the functional areas may be accomplished using empirically-tested tools or those developed by the nurse herself within her practice setting, drawn electically from her education and experiences. Other tools used in the practice of school nursing include apparatus such as audiometers, sphygmomanometers, and otoscopes.

An example of the school nurse's use of these tools is reflected in her role functions at a preschool screening clinic. She might utilize a locally-developed health inventory, an empirically-tested tool such as the Denver Developmental Screening Test, as well as apparatus for testing visual and auditory acuity. If health problems are identified as a result of using these tools, she may use a structured or nonstructured interview format to gather data for a nursing history. The child's completed physical exam form coupled with the nursing history provide the data base for the determination of a nursing diagnosis. The diagnosis in turn generates a plan for follow-up to facilitate the child's adaptation to kindergarten.

Systematic Process

The last concept included in this framework is "systematic process," which can be defined as a methodical series of actions or operations employed for the achievement of specific results.[12] Use of such a process ensures a holistic and comprehensive approach for identifying and meeting the nursing needs of students.

There are many systematic processes which are directly applicable to the practice of nursing, including the following: (1) nursing process, (2) research process, (3) health education process, (4) epidemiological process, (5) administrative/management process, (6) planned change process, (7) legislative process, and (8) contract-setting process. The processes may be utilized singly, consecutively, or concurrently depending on the situation. An example of the multiple use of these processes might be an outbreak of rubeola (red measles) in an elementary school population. Initially, the school nurse would be confronted by a small number of children presenting vague symptoms such as fever, rhinitis, and malaise. Her use of the nursing process would begin with physical examination skills (tools) and interviewing techniques (helping relationships) to obtain a nursing *assessment.* The assessment would become the basis for her *intervention,* which would involve exclusion from school for the child and health teaching for parents about symptomatic treatment and the importance of medical follow-up. When her subsequent *evaluation* reveals an increased incidence in rubeola cases, she will need to employ epidemiological investigative techniques to identify the reservoir of the infection. Once identified, those students who constitute the reservoir would also be excluded from school. The nurse would need to use the health education process with school personnel, children and families to explain the etiology and control of the disease, and to encourage specific protection such as immunization for the susceptible population within the school, family, and community. If the number of susceptible individuals is sufficiently large, it may be advisable to plan and conduct an immunization clinic, which would require use of the administrative/management process.

Conclusion

Although we recognize that the framework presented here is only one possibility, we believe that it provides a comprehensive basis for the practice of school nursing.

It is also a means for meeting Lysaught's challenge, i.e., to provide leadership, commitment, and development of a broadly based child-care practice. Basing her practice on this framework which emphasizes "prevention" and "health

promotion," the school nurse is in a unique position to facilitate the attainment of high-level wellness of the children, families, and school personnel whom she serves.

Her consistent and conscientious application of the concepts further provides her with a basis for articulating and documenting her interventions and their outcomes, so that she can survive the budgetary cutbacks that threaten the continued existence of school nursing.

This article describes the framework which will be more fully discussed in our forthcoming book, SCHOOL NURSING: A FRAMEWORK FOR PRACTICE, to be published by the C. V. Mosby Co.

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Medical Considerations for Multiple-Handicapped Children in the Public Schools

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Recent legislation at the federal level and in the state of Washington requires that public school districts provide services for all children of common school age, regardless of the severity of a child's handicap. Before these laws were enacted, districts were able to refuse entry to children they were not equipped to handle. In addition, these laws enable districts to conduct programs for preschool handicapped children. The resulting expansion of programs has resulted in special problems of adequate, safe supervision of the children and of protection of staff from unusual hazards to their health.

At the Maplewood and Lake Washington Handicapped Children's Centers, we have had an opportunity to note concerns and develop programs oriented toward the safety of the children and staff. Both centers have students classified as multiple handicapped. By definition, classification indicates that a child has "two or more handicapping conditions, each of which is so severe as to warrant a special program were that handicapping condition to appear in isolation." Also, both centers have classes for preschool-aged handicapped children.

This discussion is organized under the following headings: First Aid, Emergency Care and Disaster Planning; Sanitation; Environment; Safety in Routine Activities; Safety in Supplemental Activities; Therapy Procedures; Staff Protection; Training and Orientation of Staff; Special Qualifications of Staff. Under each topic, there is a discussion of concerns and some practical suggestions regarding the management of the situations cited.

*Deceased

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First Aid, Emergency Care, and Disaster Planning

Children attending the special education centers are subject to the usual cuts, bruises, and sudden illness which occur with all children at school. The same general emergency information which is obtained on all enrollees in the district is obtained before the child attends school. This includes information of where parents can be reached; who is empowered to make emergency decisions in the absence of one or both parents; name, address, telephone number of the child's physician and alternate physician; any known serious medical condition; the name of a neighbor willing to be called to provide transportation home for a sick child. Also the same written instructions and usual first aid supplies furnished for all buildings are available to the staff. In addition, physicians of children sufficiently handicapped to be placed in special education classes are asked directly whether there are any precautions or limitations recommended in planning the child's program and any observations to be reported to him/her.

For children with certain medical conditions, specific information is needed in order to (1) plan a school program that would not result in further injury to the child, (2) anticipate areas of trouble or activities which might lead to trouble, (3) recognize signs that something is going wrong, and (4) provide for prompt, effective emergency care. For children with the conditions listed below, the minimal information given after each condition is obtained from the child's physician and kept readily available to teachers, aides, or anyone dealing regularly with the child.

Epilepsy, Convulsions, or Seizure Disorder: The type of reaction the child shows, (grand mal, petite mal, psycho-motor equivalents); the usual severity of the reaction (length of time, time until back to normal); dates of last three seizures and provocation if known; prodromal symptoms (i.e. can child anticipate seizure); special precautions for this particular child; instructions as to source of medical care in case of emergency and any special arrangements which have been made by the parents. If the child is receiving medication, the school should know the duration of the current type, when it is administered, and the usual side effects. In cases where a child has a history of prolonged, severe seizures, it is advisable to have definite written instructions from the child's physician as to length of seizure and/or specific observations which indicate the child should be sent to a previously-designated emergency care facility.

Congenital Heart Disease: Severity of condition; limitations of activity; general prognosis; symptoms indicating trouble; current medication. It also should be noted if streptococcus infection is diagnosed in any child in the class, the parents of a child with congenital heart disease are to be notified.

Rheumatic Heart Disease: Severity of condition; limitations; general prognosis; symptoms indicating trouble; current medication. Again, a note should be made to report any streptococcal infections in class to parents.

Hemophilia. Fragility of child's situation; limitations of activity; usual immediate management of injury.

Chronic Kidney Disease: Severity, prognosis, special known precautions or hazards. Streptococcal infections in class should be reported to parents.

Severe Allergy to Insect Bites. Severity of allergy; type of insect concerned; expected reaction. If a very severe reaction is anticipated, preparation for immediate management must be made.

Diabetes. Length of time child has had disease to help determine whether child's disease has reached a stable situation; current treatment; provisions for unusual circumstances such as exertion or excitement; frequency of insulin reaction; signs of insulin reaction in the child; provisions made for guarding against severe insulin reaction.

Allergy to Drugs or Antibiotics: Drugs to which allergic, severity, and manifestations of reaction.

Chronic Blood Disease. Type of disease and prognosis; symptoms likely to occur at school; special recommendations or precautions.

Condition With Abnormal Functioning of Breathing or Swallowing. Severity of interference; precautions and recommendations regarding food and liquid intake; types of activities allowable and types to be avoided.

In all these special conditions, the school has in writing from the parents the desired source of medical care in case of a situation seen as a true emergency by the school staff. The schools also request the parents to state the type of transportation desired and an outline of any prior arrangements made by the parents. The child's physician is asked to provide any additional information which he sees as a useful guide to the school staff in the management of an emergency.

General definitions of a serious medical emergency are available and known to the staff; and in each building, a procedure is outline which is to be followed. A serious medical emergency exists if any of the following conditions are present in the patient: inadequate respiration or breathing difficulty; bleeding which is difficult to control; state of shock (pale, cold perspiration, weak, and rapid pulse); unconsciousness (beyond ordinary fainting); extensive burns (heat, chemical, electric).

For the children whose development or medical conditions place them in a particularly vulnerable position to serious episodes of choking, circulatory failure, or central nervous system damage, arrangements are made to obtain emergency medical service from a local facility prior to their attendance at school. The parents authorize emergency care for the child by signing a statement legally acceptable to the hospital. The parents also request the physician supervising the child to send to the hospital the medical information necessary to have adequate emergency care provided. The school makes arrangements with the local emergency transportation system (e.g., fire department, aide car) for immediate response in case an emergency call is received from the school. We have found that a visit to the center by the administrator of the local emergency service leads to greater cooperation.

Since much of the basis of this emergency planning depends on the medical situation of the child, it is essential that scheduled communication with the child's source of medical care be established and maintained by a staff member.

Disaster planning can be modeled after the district plan with the additional instructions necessitated by the condition of the children. Warning systems must be of a kind which are obvious to the children. The usual systems which depend on sound must be supplemented by those which can be noted by children who cannot hear. Flashing lights may be used, but the installation of a visual alarm system must be carefully evaluated to be sure that all areas where children might be are included — work rooms, wash rooms. If a child can neither hear nor see, his removal from a danger area needs to be assigned to a specific member of the staff. Impaired or complete lack of mobility and dependence on wheelchair transportation must be considered and staff assigned accordingly. As a final consideration, children with impaired powers of judgment must be protected by adequate adult supervision and a simple routine they can be expected to follow. All routines for disaster protection are outlined in writing by the building administrator, known to and followed by the staff. Usually in this planning, specific personnel are assigned to specific tasks, including a careful checking arrangement to assure that all children have been afforded safety as planned.

Sanitation

Because of the physical and/or mental limitations of some of the children and because of their apparent vulnerability to infection, proper sanitation and efforts for disease prevention are particularly important.

The first consideration is to prevent the direct spreading of disease from child to child. The children are likely to be less able to describe complaints and feelings. Regular, careful observation by staff to judge whether a child has significant signs of upper respiratory or gastro-intestinal or skin infection, comparing present with past observations is required. Children with symptoms and signs indicating likelihood of acute infection are sent home as required by regulation of the State Board of Health. Other efforts to prevent the spread of infection are made by careful, consistent training in routines which include: handwashing after going to the toilet; cleaning up before handling food; each child keeping his own lunch to himself instead of trading; each child wearing his own clothes, particularly caps and hoods.

Because there is no control over production, bringing food from a student's home for a whole class is discouraged. Treats are furnished from commercial sources.

The inclusion of children in the programs whose developmental levels and/or handicapping conditions result in their not being able to control bowel and bladder presents a new and serious sanitation problem. Diapering areas are provided which are: at a height convenient for staff who are handling the children; do not require too much lifting; convenient to running water; protected so children won't roll off.

Equipment is provided for handwashing of staff between changes of children; for proper cleansing of diapering areas; for disposal of used diapers. Diapering is scheduled so that staff have time to follow clean procedures. It was thought best that the school staff not accept the responsibility for washing and reusing diapers unless standards for public laundry can be followed. Even if these requirements can be met, the washing machines used should not be those in the home economics unit of the school where food is also being prepared. Thus, each family is asked to furnish disposable diapers or regular diapers and plastic sacks into which the used diapers can be dropped, unrinsed, after removal and sent home with the child. If any child shows evidence of acute intestinal infection, the procedure is reviewed and extra precautions taken to prevent spread of infection.

Older children who are incontinent or have special arrangements for collection of wastes, such as plastic bags, require individual planning and arrangements. Provisions are made for the child to have available a complete change of clothing. If possible, an isolated shower is designated in which a child can be washed after wetting or soiling. The psychological as well as aesthetic values of this procedure are apparent. When bag arrangements have to be changed at school, careful instructions, precautions, observations, and recommendations are obtained from the child's physician before any member of school staff accepts this responsibility.

Staff should be reminded of the particular vulnerability of many of the children and of the close contact required in working with the children. A staff member in the early stages of infection or with a severe infection should stay away from school.

Environment

Facilities for housing children with severely handicapping conditions were evaluated for several safety and convenience factors in addition to those which apply to the children in the regular program. Ramps for wheelchairs are provided. Doors, including those into restrooms, are wide enough to allow wheelchair entrance. Wall bars to facilitate moving in and out of wheelchairs are provided in areas such as toilet booths. Locked cupboards for cleaning agents, disinfectants, and duplicating fluids are provided. Classroom furniture is stabilized so a child cannot pull or push furniture over on self or classmate. Toys are too large to swallow, too tough to break and free of sharp points or edges. Broken glass or other sharp objects are disposed of in a container not accessible to the child. Electric plugs are covered to discourage exploration. Electrical and power equipment is kept in good working order, equipped with safety devices and used only by designated students with adequate supervision. Hot water supply is regulated so it is impossible for a child to obtain burning hot water. Pins, buttons, coins, and filmy plastic are kept out of the reach of younger students and students with impaired judgment. All medication is kept by an adult in childproof, properly-labelled containers in a locked drawer or cupboard.

Staff members involved in changing diapers for children are reminded to prepare supplies and equipment before putting the child on the changing table and then stay with the child.

Routine Activities

In planning routine programs and activities for the children, consideration of the general and specific limitations of the children necessitates certain adjustments. A child's ability to chew and swallow determines the texture of food he is able to eat. There are some developmentally-young children and some organically-damaged children who are not able to manage a regular school lunch diet safely. It has been possible to arrange an alternate or junior lunch for such children with the food services in both districts. The junior lunch provides only soft foods generally suitable for about a normal 1 year old. This eliminates the daily checking of trays by the teachers to decide what is safe for the child and what must be removed from the tray. In addition, some children must be fed. The capability of staff members and the degree and kind of the child's handicap are considered in the assignment of feeding responsibilities to the staff. In a few instances, teaching a child to swallow may actually be a part of the child's total instructional program.

Transporting the children also requires special consideration. Within the building and on campus, any mechanical aids to mobility — walkers, tricycles, and wheelchairs — are demonstrated to the staff so that inherent problems in the use of the device may be understood by all staff. The mechanics of a wheelchair — proper use going up and down curbs, how to lock wheels in position, how to belt children into chairs, proper transfer of children in and out — are demonstrated by a professionally-trained person (usually a nurse, physical therapist, occupational therapist, or physician) . No student may propel a chair for another without specific instruction from the teacher. Wheelchairs are not to be used as toys. All transporting activities must include adequate adult supervision. Children are not to be carried by staff because of the danger of slipping or falling with the child.

Transportation from school to home or other destinations should include equipment for holding children firmly in seats, bassinettes for those unable to sit in seats, apparatus and/or ramps for loading wheelchairs and means for stabilizing chairs in the bus in addition to the usual safety measures for normal children. Bus drivers are required to have successfully completed a course in industrial first aid. The driver of the bus is informed which children in the bus are likely to have any kind of emergency problems, such as seizures, and are prepared to respond appropriately. In situations where very fragile children are being transported, an aide rides the bus with the driver. School staff supervise loading and unloading buses on a schedule in order to avoid crowding of children in entryways and walkways and to provide adequate adult supervision at all times.

Playground activities require careful consideration and supervision. It is imperative that supervisory staff be circulating constantly to maintain safe conditions and cover for emergency situations that might arise. For instance, the use of baseball bats should be strictly regulated, children should not stand near moving swings and children prone to seizures need to be attended on slides.

Supplemental Program Activities

As each activity is planned, the individual condition of each child determines the amount and type of his/her participation. For example, a child who cannot turn over or does not have the judgment to do so is not placed in the sun where his eyes are exposed to direct rays.

A file of necessary emergency information accompanies children engaged in activities away from the school building — picnics, cookouts, field trips — with special information as to where parents may be reached during the time of the excursion. With the children whose judgment and physical capabilities are limited, at least one adult is provided for each two students. Safety plans parallel those made at school. Often food usually thought of as cookout or picnic food — such as weiners with hard skins, raw carrots, raw apples — are not appropriate for children in these schools.

Fires, wading activities, trail hiking are planned with a thorough knowledge of the environment and the children for whom the activity is scheduled. For example, if it is known that a child is undergoing medical treatment (such as having tubes in his ears) for hearing impairment, he is not scheduled for swimming until this has been cleared with his physician.

Clearance is obtained for any programs planned which might put unusual stress on the children. Field trips, physical education, swimming or activities which require unusual endurance require separate clearances.

Therapy Procedures

Frequently children who are placed in the special education center are receiving maintenance medication. Requests are often received for this medication to be administered by the school staff some time during the school day. First, it must be determined whether a schedule requiring administration at school is really necessary. Then the child's physician is asked to provide a signed instruction sheet, and the parents are required to furnish medication in child-proof containers labeled with the child's name and the name of the medication.

When immediate medical administration is required — for instance, a severe allergic reaction following an insect sting — arrangements are made for a member of the school staff to be instructed and/or trained to give the proper medication in an effective way.

One area of service offered to children in a regular program which is not always made available to the children at the centers is the immunization program. Rather than subject the children to procedures which may upset them physically and psychologically, letters are sent home advising the parents of the state immunization requirements, suggesting that the children in the center should be treated individually and that parents communicate with their physician asking for advice. Hours, days, and location of public clinics available in the area are given.

Therapy procedures which are carried out by occupational and/or physical therapists and unusual nursing procedures are done only after instructions are given by the child's physician. Instructions must be clear and precise for each situation that may occur. Vague directions, requiring staff members to exercise their judgment as to which instruction is appropriate, are not acceptable. Services requiring clearances are deferred until proper clearance has been obtained (e.g., voice training in the presence of hoarseness) to prevent further damage.

Staff Protection

The safety of teachers and other staff is a concern, and plans and procedures for protecting them must be made. Teachers, communication disorder specialists, occupational therapists, physical therapists, aides and others have close physical contact with the children in instructional, therapy and daily living activities. Children with infections may not have the judgment or capability to protect themselves or others from the spread of infections. Periodically, especially when there are many communicable infections in the area, staff members are reminded of their vulnerability and cautioned to be extra careful in their work with children.

The necessity for lifting and transferring students bodily to and from wheelchairs and from place to place in the school presents an unusual occupational hazard. Each year, new staff members are instructed how to lift and move students with the least danger to themselves. This instruction and demonstration usually is done by an occupational therapist, physical therapist, nurse, or combination of these personnel.

Training and Orientation of Staff

Early in the school year, new staff members are instructed in the principles necessary to provide safe management to the children. All staff members are alerted that special supervision and management is needed in the playground, lunchroom, walkways, and classrooms. It is stressed that is is important to become familiar with all information available on a child and understand the significance of certain diagnoses on the way in which a child functions. Valuable background information for a teacher may include the following: That heart defects may lead to easy fatigue; neurological defects may result in seizures or uncontrolled muscle reactions to unexpected or overwhelming stimuli; allergies may cause reactions to bee stings, foods; Down's Syndrome children may have frequent upper respiratory infections; anemia may lower resistance to infections; visual defects may result in unusual sensitivity to direct light, including sunlight; inability to shift one's body may result in pressure sores on skin.

Staff members are reminded that certain characteristics of the students make accidents more likely to occur. These characteristics include poor judgment; lack of awareness of danger; impulsiveness; restlessness; inability to communicate; low pain threshold; abnormal muscle functioning causing inability to swallow, chew, walk, stand, use arms or hands correctly; decreased vision; decreased hearing.

Changes in the usual routine or periods of stress are identified as potentially dangerous times for accidents or illnesses. Examples are field trips, holidays, beginning or ending of school year, change in school personnel responsible for students, marked change in weather, stressful times in the child's home when parent (s) are ill, absent, or preoccupied with unusual concerns.

It is suggested that the staff plan ahead to prevent problems during these times by: providing adequate supervision by adults who know each student's significant characteristics that might predispose to accident or illness; by having children equipped with appropriate clothing for the weather and terrain of a field trip; by prevention of fatigue during a new activity; by preparation for emergency equipment, procedure for care, and information necessary to locate parents; by delegating the supervision of specific students to specific adults prior to a field trip or new activity; by having the limitations and capabilities of each child in mind when an activity is planned involving the child and making necessary adjustments.

Teachers and other personnel are informed at the time of a child's enrollment and again each fall of children considered to be in particularly vulnerable situations and of recommended procedures in the event of emergency. The responsibility for this orientation is assigned to a specific staff member.

It is strongly recommended to all staff that they take courses in standard first aid and in cardio-pulmonary resuscitation if possible. Some of these courses are provided by the school district, some by local community agencies.

Regular, periodic meetings of all staff are held to consider safety routines, procedures and recommendations. All routines are written and responsibilities for activities assigned.

Special Qualifications of Staff

In order to prevent accidents, maintain a safe environment and afford adequate supervision, it is necessary for the staff to know the children's limitations and be able to recognize behaviors that might precede the occurence of an accident.

The staff is expected to supervise children at all times and be alert to unsuspected hazardous conditions. The personel who, by training, are oriented to safety and prevention — such as the physical education specialists, nurses, physical and occupational therapists, communication disorder specialists, and physicians — feel a particular responsibility to stay alert to conditions and situations which should be changed.

Every member of the staff has an important part to play in protecting and caring for the children being served in these special education centers, and an effort is made for all to feel and accept that responsibility.

Note: Forms, directions and written procedures to help with activities described have been developed for use in our centers and examples may be obtained by request to authors.

Cerebral Palsy — A Continuing Battle

By Ruth A. Gullerud
Guidance Counselor
United Cerebral Palsy of West Central Wisconsin, Eau Claire

To be born with cerebral palsy in the late 1940's was to experience the dawning of a new day. Cerebral palsy — a tragedy to some, a cruel blow of fate and the beginning of frustration to others — to me its onset heralded the opening battle cry of a challenging warfare. Entering the world during a period when modern medicine was increasing in ability to preserve high risk infants and when atypical children were not being hidden in closets and attics, I would be allowed to survive my traumatic birth — a birth bringing brain injury by instrumental forces and permanently separating me from my mother by her death — and I would be ushered into a society not yet prepared to accept me as an equal member.

Early diagnosis with intervention would become the first battle front as my grandmother, who raised me, called the attending obstetrician to describe the way my right leg consistently sprang back into a contracted position and my head refused to hold itself upright. His cool response, "We know about it, don't worry," placated her until I was 2 years old when a county health nurse pronounced the unfamiliar words, "cerebral palsy" and referred us to a pioneering orthopedic specialist, Dr. John F. Pohl.

The year 1950 brought our family into contact wih the marvelous compassion of Dr. Pohl, who had become an indefatigable partner in the warfare against the destructive effects of cerebral palsy. In that same year, he had published a book describing cerebral palsy and its treatment, a book which he ended: "The happiness of the child and desirable social adjustment depend upon an opportunity for the cerebral palsied child to share wth others the joys, sorrows, hopes, and aspirations which are as much a part of his life as of any other human individual." Dr. Pohl shared his book during our first office visit and from that point on, those closing phrases became the working philosophy of habilitation for my family. Together we would labor to assure me opportunities to share the joys, hopes, sorrows, and aspirations of any other human being.

So began a long chain of drops of perspiration from my father's and my own brow as we practiced the prescribed exercises, of tears as I was sent on huge buses to special schools long before I thought little girls should leave their dolls, of therapeutic pulling and stretching leg muscles and surgical procedures which rudely interrupted the carefree gaiety of childhood. And although I quietly understood that I was different than the other children running after their ball in the yard, little did I realize that the laborious procedure of habilitation I was enduring was indeed a unique blessing. For we gradually became acquainted with other families in the midst of the same malady, older ones whose child remained undiagnosed and untreated, younger families whose child was still being denied education and therapy.

We learned to know families whose experiences had produced feelings of bitterness, guilt, and anger, feelings which eventually penetrated down to their child, producing the piercing question, "Why me?" And as societal opportunities improved and protective legislation began to increase, we continued to encounter parents wracked by feelings of undeserved guilt and unquenchable bitterness. Even today, the same emotions spring forth in parents in my counseling office, feelings which expanding rights and legislation cannot begin to penetrate.

While becoming acquainted with others, my own family supported me through my childhood, nurturing hopes of a successful conclusion to our mutual struggle. Therapy continued throughout grade school as I attained insecure footsteps by walker, crutches, and finally unaided. Cheers of victory were voiced by therapists, for ambulation was considered a number one goal on the way to the conqueror's crown. Slurred speech was slowed and painstakingly corrected, writhing fingers were trained to feed and write, to dress and wash as daily activities were consistently encouraged to approach nearer and nearer to "normal" behavior. And I doggedly followed, usually convinced that if I persevered, the final goal which we now call "normalization" would eventually be mine.

During those early years, experiences of acceptance by peers were uniquely happy ones for me compared to others around me who were also cerebral palsied. Commonly encountered rejections, ridicule and peer avoidance were not generally mine. Because I bantered freely within a close group of peers throughout my adolescence, by the close of high school years, it was my logical belief that life experiences should continue to approximate those of my fellow classmates with whom I had been mainstreamed (an educational experience which occurred admittedly before my time).

However, society and even the world of rehabilitation seemed ill prepared to support the fulfillment of my Quizotic suppositions.

My peers quite naturally moved into realms of college, careers, and marriage and as I attempted to blithely follow, walls of stoney obstacles barred my path. Plans to attend college, which seemed quite naturally appropriate, were delayed by rehabilitation evaluators who pronounced college to be unrealistic "if you can't toilet yourself." Career choices were stymied when I explored library work and was counseled that it was an unacceptable choice since I "couldn't climb ladders." And while the former two paths were supported by family members, the third aspiration of marriage was tabooed by society and family alike.

Late teens and my early twenties laid the arena for the fiercest of the battle fronts thus far fought. It was while I was

completing my undergraduate degree, an opportunity I had won on a trial basis, and I was looking ahead to a career which I could not envision, that I surrendered to an overwhelming depression. Within the battle ditches, nursing my scars, I voiced my dilemma in poetic lines.

A WHEELCHAIR CONFINES NOT MY HEART

Hear my cry — I am a woman,
a woman who, amidst crowds of people,
is desperately searching for one look
of love given freely, without pity;
but all I find is an impenetrable wall
of inquisitive stares and sympathetic tears.

These cold spinning spokes of my chair will bring me no tears
if you will talk to me as any other women.
Ignore this hardware surrounding me and climb over that wall
you have built in your mind. Let me into the world of people
and forget your useless, unwanted pity.
If that be all you have to offer, turn away your look.

One day, I took an honest look
at myself: I saw what you see and bitter tears
ran from my own eyes — partly because of self-pity
but more because I alone could hear the cry of a woman
inside these outward infirmities — the pleading cry which people
would never hear because they can't break down their prejudiced wall.

I am suffocating behind your sympathetic wall.
I search for friendship, but everywhere I look
I meet kind, understanding people
who nod their heads in attempted acceptance and whose tears
blot from their view my pleas to be a normal woman;
and love I could offer is strangled in a blanket of their pity.

My lonely state is not solely caused by pity.
I have successfully constructed my own prison wall
and willingly become something less than a woman,
accepting without argument the patronizing looks
and wallowing in the sorrow of my own tears,
saying, "I don't belong in the world of people."

Still my greatest need is to love and be loved by people.
I want friendship without pity
and a request for my love without tears.
I must tear down this dividing wall
before my heart grows cold and no longer looks
for the warm human life of a woman.

Hear me, people. Help me penetrate the wall
of the world's pity. Look
past your tears and approach me only as a woman.

(March, 1971)

If philosophy had not progressed beyond these lines, it would have been a bitter ending indeed. And, in truth, many of the young adults having cerebral palsy whom I counsel today seem to be immovably locked into a similar self-destructive state of mind.

But fortunately, new challenges ensued for me and after healing my wounds through counseling help, I returned from the ditches to the field. My greatest foe then became potential employers and public education and awareness was an obvious stumbling block. Throughout my employment search, ability and training were most often shadowed by irrelevant implications of disability. Not until I had gone the extra 100 miles in obtaining a masters degree and some work experience (a home stretch which is an unrealistic expectation for a large majority of individuals having cerebral palsy) did employers at large even grant me equal opportunities to interview for appropriate openings. Newly passed laws of affirmative action accomplished nothing toward increased understanding of the oft misunderstood condition of cerebral palsy.

Figure 1—Ruth Gullerud is a guidance counselor with the United Cerebral Palsy of West Central Wisconsin, Eau Claire.

The challenge of employment break-through has temporarily been conquered as I work in my counseling position at United Cerebral Palsy. However, since society is comfortably appeased to think that this is the appropriate agency to employ me, the struggle of ability over disability may be renewed when I attempt to secure positions with other agencies.

Personal serenity has grown with added years and experiences but further campaigns of victory and defeat lie ahead. Rights to public transportation, to employment, and to other places of choice are still denied me in towns of moderate to small size. Accommodations and personal assistance in independent living must for me and others having cerebral palsy surpass the restrictive confinement of the frequently sole availability of nursing and group homes. A growth of sensitivity and acceptance must be perceptible in societal and familial attitudes toward my own freedom of choice between having a marriage partner or remaining single. Progress must advance from today's reverence and special compensations for the cerebral palsied consumer to acceptance of him as an anonymous but equal member of society.

The erudite reader may well reflect that my own personal narrative of battles fought and fields conquered is the past woe of the last generation who are now young adults and that growing infants and children face no real replication of these thorny questions. Indeed, modern American legisla-

tion and philosophy have afforded children having cerebral palsy more opportunities than have been imagined thus far in history. And the state of Wisconsin has taken a marked lead in the progress. Yet, let us take a look at the needs still arising among those children and their families.

The professional world has broadly recognized early case finding, diagnosis and treatment of a young age as a vital link to successfully ameliorating the ultimate effects of cerebral palsy. Still, in 1978 there were found several children at the age of 7 to 14 in Wisconsin who had not been identified and some who had not been brought to the attention of any educational system. To the amazement of the medical profession, parents still report that physicians have avoided pronouncing a diagnosis or the presence of any anomaly until their child is 2 or 3 years old and the parents seek out an answer to obvious abnormalities in development.

We frequently encounter families who have foregone vacations and many recreational breaks ever since their cerebral palsied child entered the family unit. Due to the absence of adequate respite care programs with which to leave the child needing special care and often because parents have not had access to counseling assistance for working out their own feelings of frustrations, the daily management of a child becomes an uninterrupted strain.

The adolescent and young teen aged consumer also continues to face conflict. Although educators and psychologists have begun to address the issue of sexual adjustment, proposed programs are still often cursory and young people dubiously question their sexual role among their peers. Older teenagers strive to fit into society's expectation of employment only to find that the only reachable avenue open to them is the sheltered facility which often has not included work activities suitable to the multiple involvement of cerebral palsy. Others may succeed in securing employment suitable to abilities, but cannot locate reasonable transportation means to arrive there nor have they acquired the adequate support in a satisfying independent living arrangement.

To summarize, translated into the sixteen services which each county is mandated by state and federal law to provide to its developmentally disabled citizens, existing needs which I perceive to be felt most acutely by those having cerebral palsy are: (1) early diagnosis and evaluation, (2) day care, especially forms of respite care, (3) counseling, (4) transportation, and (5) special living arrangements.

However, perhaps the most basic ingredient for the assurance of the goal of total integration for individuals having cerebral palsy lies in increased public awareness and sensitivity. Many of us do not need specialized recreation, sheltered employment or separated places in which to live, if the individuals of the society around us willingly accept us also as individuals. Each member of society "marches to the music" of his/her own drum; the rhythms of mine may be changed slightly by cerebral palsy but it is also varied by my abilities, interests, creed and avocations. Battlefields will be peaceful when each of us listens to our neighbor's drum.

Identification of Family-Based Dialects at the Pre-K Level

By Jean Rothe
Formerly School Psychologist
School District of Beloit-Turner

Continuing research and experience show that "educational failure is primarily linguistic failure" (1). Schools are urged to put effort into the area of speech-language exceptional and special needs, in the application of the following federal and state laws: early identification of handicapping conditions; the involvement of parents in the processes of identification and of developing programs for remediation; and evaluation that does not discriminate because of race, sex, or social class.

Note that the rules and regulations state that educational needs resulting primarily from poverty, neglect, delinquency, social maladjustment, cultural or *linguistic isolation* or inappropriate instruction are not included under Chapter 115 (10). That is, educational needs resulting from any of the above named list are not considered to be a *handicap* and will not be included under Chapter 115.

"Linguistic isolation" refers to isolation from the use of Standard American English. In any community (and a single family can be identified as a community), the members of the community still communicate with each other, but perhaps with different rules of grammar and different values. These linguistic differences are called "social dialects" by linguists.

Let us orient ourselves to this idea of "social dialects." The American Speech and Hearing Association (ASHA) recently published some definitions that separate speech and language *disorders* (handicaps) from speech and language *differences* (dialects) (9).

The study of social dialects explores the relationship between

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This article is based on data gathered thru the Wisconsin Resource Center Project #61254, 9-30-76 thru 6-1-77.

> speech and social class, race, sex, and occupation. Thus, even within one small geographic area, several rather distinct speech patterns may exist that will mark different speakers. . . The speech-language pathologist must ask if a particular feature produced by an individual is characteristic of the language of that individual's peers or is peculiar to the individual speaker. If the former is the case, it should be considered a legitimate aspect of the dialect diversity; if the latter is the case, it should be considered a disorder.

Thus the family's typical speech and/or language must be known before a decision can be made about the child's disability or difference.

In an attempt to develop a preschool screening device that would differentiate between speech-language *pathology* (handicap) and speech-language *difference* (dialect), the school district of Beloit-Turner made a study of the language skills of 94 kindergarten children early in 1977. The population of Beloit-Turner is classified as "rural," though about half of the population live in what is considered a "suburban" area. There is a wide range of income in the district. The total school population in 1976-77 was 1500, almost all Caucasian. Of the 94 kindergarten children in the study, one was Native American and one Hispanic.

We wanted the answers to seven questions. A brief report of the "answers" in terms of research results will follow each question listed below.

Question 1 — Is Bernstein's theory true in a practical school situation, that "Educational failure is primarily linguistic failure?" (1). Our sense of direction came from a series of inservice days for Title I teachers and aides, presented in the 1975-76 school year through CESA 15 by Dr. Lee Gruenwald and Sarah Pollock. The inservice programs emphasized *total communication process* within the classroom, as proposed by Cazden (3). The year 1976-77 was an ideal time to test our theories because the district that year implemented for the first time the Lippincott Beginning Readiness Series (7) in the kindergarten giving a much stronger academic emphasis to kindergarten than before.

Answer 1 — It was found that a child's success on a certain language measures did correlate with school success. The more mature a child's syntax, on a developmental scale suggested by Brown (2), the more successful in kindergarten the child was.

Question 2 — Is school performance or ability related to the socioeconomic class of the students?

Answer 2 — Socioeconomic status cannot be rigidly defined in the changing midwestern American society as typified by the Beloit-Turner District. But the simple bimodal classification of the father's job as verbal or nonverbal (8) did cut across all economic levels and did correlate with the child's school success.

Question 3 — Is there a way to avoid possible discrimination brought about by our use of Standard American English tests? We planned to base our evaluation of the child's language on a spontaneous speech sample. Such a sample is child-centered rather than instrument-centered and therefore appears to be most culture-free and nondiscriminatory. Earlier research on spontaneous speech developed a long process of several hours of taping (over several days) of a child's speech in at least three different environments (the home in routine and in spontaneous situations; the classroom; and the playground) (2). For this study, it was expected that a language therapist would get adequate information about a child's spontaneous communication skills in 15 minutes in a carefully contrived situation with appropriate toys and techniques.

Answer 3 — We discovered that special training is needed for language therapists to collect this 15-minute sample of spontaneous speech. A training manual and an inservice program with video tape was developed and was reported at the ASHA convention in San Francisco in November 1978. The validation of such an inservice program has not yet been accomplished.

Question 4 — Is it possible that the social isolation of children who live in rural areas might contribute to a delayed development of language?

Answer 4 — Analysis of variance of the differences in language measure scores as a function of the demographic variable rural/suburban showed no significant relationship.

Question 5 — At the pre-K level, is a developmental scale of syntax acquisition the best measure of language development?

Answer 5 — Yes. The first 14 morphemes (scale developed by R. Brown) proved more effective than MLUM (mean length of utterance in morphemes) or DSS (Developmental Sentence Structure) (5) or DST (Developmental Sentence Types) (5).

Question 6 — Is there a possible relationship between the development of language acquisition and the development of other representational behavior as suggested by Piaget? (6)

Answer 6 — In this study, "Draw-A-Man" (4) was used as a representational skill in addition to all language tests. In comparing two matched groups of kindergartners, 14 in language therapy and 14 not in therapy, on scores of several language production tests and a five-part language comprehension test, as well as a series of cognitive tasks, the *only* item that distinguished between the two groups was the representational task, Draw-A-Man. Thus it appears that the children declared language-handicapped did also indicate a handicap in another representational area, drawing.

Question 7 — With these questions answered, can we then develop a screening instrument that will separate exceptional educational needs (EEN) candidates from special educational needs (SEN) or Title I candidates?

Answer 7 — A screening device is only a rough indicator, and probably can be developed. The complete diagnosis and final decision about whether a child is EEN or showing cultural differences must be made by the multidisciplinary team (M-Team). The M-Team will need to work personally with the parents to determine some of the elements of the communication style, function, and values of the family that are affecting the child's communication skills.

Conclusions

Two elements (b and c) of our proposed three-element screening device have yet to be validated.

a. The Boehm Test of Basic Concepts showed the highest correlation of all language measures with school success. It has shown over time valid and reliable qualities.
b. The Draw-A-Man test should be the object of further research in the area of "representational" behavior and whether its deficit is a "specific cognitive deficit".
c. An analysis of a 15-minute sample of spontaneous speech by counting the first 14 morphemes of the developmental scale is still a good possibility for examining the child's language production. Although much more work must be done to validate the training procedure and the reliability of a 15-minute sample, the training manual and program of inservice may prove to be one of the major results of this study.

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Progress Toward a Free Appropriate Public Education

The following is a reprint taken from the March 12, 1979 Liaison Bulletin (Volume 5, Number 8) of the National Association of State Directors of Special Education. This reprint is a summary of information provided to Congress by Dr. Edwin W. Martin, deputy commissioner, Bureau of Education for the Handicapped, in his report on the Implementation of P.L. 94-142. This executive summary provides an overview of the findings of the 215-page report which is designed to provide information to answer six basic questions.

Executive Summary

This is the first of a series of annual reports to Congress on progress in the implementation of Public Law (P.L.) 94-142, the Education for All Handicapped Children Act. The act calls for reports to be delivered to the Congress each January. This report describes activities occurring during the year preceding the effective date of the act (school year 1976-77) as well as during the first year of implementation (school year 1977-78). Highlights of the report are organized by chapters.

Chapter One: Are the Intended Beneficiaries Being Served?

- About 3.6 million handicapped children were served under P.L. 94-142 and approximately 200,000 handicapped children were served under P.L. 89-313 during the 1977-78 school year.
- States served 7.4 percent of the nation's school-aged population as handicapped; however, states varied in their proportion served from 5.2 percent to 11.5 percent.
- Previous estimates of the prevalence of handicapped children indicated that approximately 12 percent of the school-aged population were handicapped. This would mean about 5.5 million school-aged children are the expected target for services. The estimate of 7 to 8 million handicapped children used by Congress includes children in the 3-5 and 18-21 age ranges, where services are not mandated under the law.
- The department has adopted a goal of improving child identification practices to insure that unserved children are located and served.

Chapter Two: In What Settings Are Beneficiaries Being Served?

- P.L. 94-142 requires handicapped children to be placed in the least restrictive environment commensurate with their needs.
- State Annual Program Plans indicated that extensive training in the principle of least restrictiveness would be provided to parents and teachers, as well as to a variety of other school personnel.
- The predominant placement for handicapped pupils during the 1976-77 school year was the regular classroom with auxiliary services.
- There still is a need for school systems to develop more options for placements of handicapped children and to alert their staffs to the availability of these options.

Chapter Three: What Services Are Being Provided?

- P.L. 94-142 requires provision of special education and related services (such as transportation or support services) to handicapped children. Because of the variety of handicapping conditions children may have, the array of possible services needed is broad.
- The average teacher/child ratios during the 1976-77 school year ranged from 1:44 for speech-impaired children to 1:10 for deaf or hard of hearing children.
- States may need as many as 85,000 new special education teachers in the next 2 years to provide adequate services to all handicapped children, but universities are currently producing only 20,000 such teachers each year.
- The Personnel Preparation Program, which provides support for training special education teachers, is increasing its support of inservice training both for special education teachers and for regular education teachers.

Chapter Four: What Administrative Mechanisms Are in Place?

- The U.S. Office of Education has completed development of regulations, a monitoring system, and an evaluation program.
- Interagency agreements have been developed with the Office of Child Health; the Bureau of Community Health Services; Rehabilitation Services Administration; the Bureau of Occupational and Adult Education; the Public Services Administration; the Administration for Children, Youth, and Families; and the Office for Civil Rights.
- As part of Program Administrative Reviews, 26 states and territories were visited during the 1976-77 school year and 27 were visited during the 1977-78 school year. During the first year, state activities were reviewed for compliance with P.L. 93-380 and

for readiness to implement P.L. 94-142 amendments. During the second year, state compliance with P.L. 94-142 was determined.

- Although state activities have been enormous, two problems continue to exist. First, many states have had difficulty establishing systems by which to monitor implementation in local agencies. Second, many state educational agencies have had difficulty establishing relationships with other state agencies which serve handicapped children. The act requires the state educational agency to oversee educational programs provided by all agencies.
- When bureau monitoring visits determine that problems exist, states are required to develop corrective actions and are given deadlines by which these actions must be completed.

Chapter Five: What Are the Consequences of Implementing the Act?

- Both state and local educational agencies are developing management information systems to keep track of handicapped children and personnel assignments.
- Special and regular education teachers and administrators, as well as parents, have devoted more time to identifying children's needs, developing individualized education programs, and determining the optimal placements for handicapped pupils.
- The current allocation formula provides local agencies with flexibility to increase those services that are most needed in their jurisdiction.

Chapter Six: To What Extent Is the Intent of the Act Being Met?

- Given that the act has only been in effect for one school year, a great deal of activity has occurred.
- Federal appropriations have increased from $315 million in FY 1977 to $804 million in FY 1979, thus providing states with a large increase in financial assistance to meet the goals of the act.
- Many of the problems that were expected to impede implementation are being resolved.
- States must increase their efforts to find undiagnosed handicapped children and provide them with the services they need.

PROFILE

June Dobbs, M.D.

For the past 5 years, Dr. Dobbs and I have been colleagues in the Department of Pediatrics, Medical College of Wisconsin and at Milwaukee Children's Hospital, Child Development Center. As an Associate Professor of Pediatrics and Medical Director of the Child Development Center, she has proven herself to be not only a highly competent and skilled pediatrician, but also a warm, perceptive, and sensitive human being. Her dedication to the welfare of children, especially those with exceptional needs, has been manifest in both her philosophy and actions. She has demonstrated that physicians and all other professionals who purport to serve the child with exceptional needs must be "people-oriented" rather than disease or approach-oriented. Through her concern with the "whole" child as the necessary basis for meeting a child's "needs," Dr. Dobbs has developed and expanded the Child Development Center into a facility providing comprehensive medical, psychological, and social service programs for young developmentally delayed and behaviorally disturbed children. She has served as chairperson of the Wisconsin Developmental Disabilities Council as well as on numerous task forces, committees, etc. and effectively advocated for comprehensive and accountable services to children with exceptional needs. For her pioneering work with developmentally disabled children, Dr. Dobbs was awarded the Thelma Stack Award in 1978; this is presented by the Council for Exceptional Children to an individual who has made an outstanding contribution in the area of service to exceptional children. As a practitioner, educator, and advocate, Dr. Dobbs has been

and is an exceptional model. Her efforts to insure the well-being of children with exceptional needs has earned her the respect of professionals and parents.

J. Jeffrey Crisco, Ph.D.
Instructor of Pediatrics
Medical College of Wisconsin, and
Director of Pediatric Psychology
Milwaukee Children's Hospital
Child Development Center

There are few pediatricians in the state who have contributed as much to the care of children with handicaps as has June Dobbs. Her clinic in Child Development at the Milwaukee Children's Hospital is a model of interdisciplinary care where students of many sorts can become involved in comprehensive evaluations and learn the techniques she has developed. The basic element of care that she teaches is an understanding and respect for the needs and feelings of the child and family. Students working in this climate learn this basic approach by her example and the child and family receive exemplary care.

Her compassion and understanding has been made available to other handicapped persons in the state by virtue of her position as Chairman of the Developmental Disabilities Council. Through this medium and through the many committees she has served on and speeches she has given her influence has spread.

We are lucky that June chose to practice in Wisconsin and we are proud to be able to honor her in this edition of the BUREAU MEMORANDUM.

Horace K. Tenney, III, M.D.
Medical Director
Bureau for Crippled Children

Over the years, Dr. Dobbs has clearly demonstrated her dedication and concern for handicapped children. She has consistently provided leadership in professional organizations both at the local and state level. She is recognized in the field as an expert by both professional and citizen groups. Her unselfishness and dedication qualifies her as an outstanding person and physician.

Darcia Behrens
Case Coordinator — Developmental Disabilities
Combined Community Services Board

Dr. June Dobbs is a truly unique person! She is the rare amalgamation of scientist and artist. Her knowledge of young handicapped children's medical conditions is superb and at the same time she is an excellent teacher, parent-trainer, and counselor. Dr. Dobbs is a model for all primary care physicians when it comes to serving the myriad needs of exceptional children and their families. Wisconsin's children are fortunate to have her skills so readily available.

John W. Melcher
Program Supervisor - Early Childhood - Handicapped
Division for Handicapped Children

During the time that June M. Dobbs, M.D., M.P.H. was the chairperson on the Wisconsin Council on Developmental Disabilities, we developed a close working relationship on behalf of persons who are developmentally disabled. Dr. Dobbs displayed a consistent level of interest and enthusiasm which was certainly contagious to all those around her. She was called upon to serve in advisory capacities at local, state, regional, and national levels and always her knowledge, experience, and creative thoughts were welcomed and appreciated.

It has been my distinct privilege and pleasure to work with and know Dr. Dobbs.

Jayn Wittenmyer
Executive Director
Wisconsin Council on Developmental Disabilities

June Dobbs successfully fills roles of wife, mother, and career woman. Frequently women with professional careers become hard and unfeminine but June has avoided this problem and has remained a warm and loving wife and mother. Family life has always been important to her and the family has been close. She is an excellent cook specializing in meals that can be prepared quickly after work. She is active in sports, enjoying backpacking, tennis, skiing, and running with her family. Her first race was a five mile run last year which she finished in good time. Her Scottish upbringing has given her skills in needlework which she continues to use creatively.

There are trying days when she questions the value of her work and gets discouraged by the lack of financing for her clinic. This crisis seems to resolve with hard work and the clinic struggles on.

June could well serve as a model for a liberated career family oriented person. She has combined these roles with outstanding success.

Dr. Harold Dobbs

We have always been very proud of our mother for her success in her undertakings not only in her career, but as a wife and mother also. It has been suggested that working mothers have less time for their children and therefore are not as good, but there is a lot of truth in the saying about quality is more important than quantity because since she wasn't home all of the time, the time we spent with her meant more, and she certainly had more than enough love to make up for times when she wasn't available. Whenever we needed her, even if she was busy, she could always find time to be there.

Janie and Kirsty Dobbs

Wisconsin Dissemination Project —

Link to Information in Special Education

By Loretta Harmatuck
WDP Coordinator
Department of Public Instruction

Do you need information on identifying handicapped preschoolers? Are you looking for materials for an inservice program for teachers of EMR children? Would you like to find some examples of physical education programs for children with exceptional educational needs? The Wisconsin Dissemination Project (WDP) can provide information about these and many other questions in the area of special education.

The Wisconsin Dissemination Project is an information service for educators. It is designed to make information and resources more accessible to teachers and administrators so they can utilize current practices and research.

In response to a specific request, WDP will conduct a computer-assisted search of various sources of instructional and research materials. Through the use of computer technology hundreds of thousands of documents can be searched in minutes to find those documents most relevant to the request. The computer search is complemented with manual searches of additional state and local resources. The results of the search are combined into a personalized information package and sent to the requestor.

The Educational Resources Information Center (ERIC) is the major source of information for WDP searches. ERIC consists of 145,000 documents in the Resources in Education (RIE) collection. Typical entries in RIE include curriculum guides, program descriptions, bibliographies, and research reports. ERIC also indexes over 700 education periodicals in the Current Index of Journals in Education (CIJE) file. There are 16 clearinghouses in the nationwide ERIC network. The ERIC Clearinghouse on Handicapped and Gifted Children, located at the Council for Exceptional Children, is responsible for acquiring, screening, abstracting, and indexing documents in the area of special education.

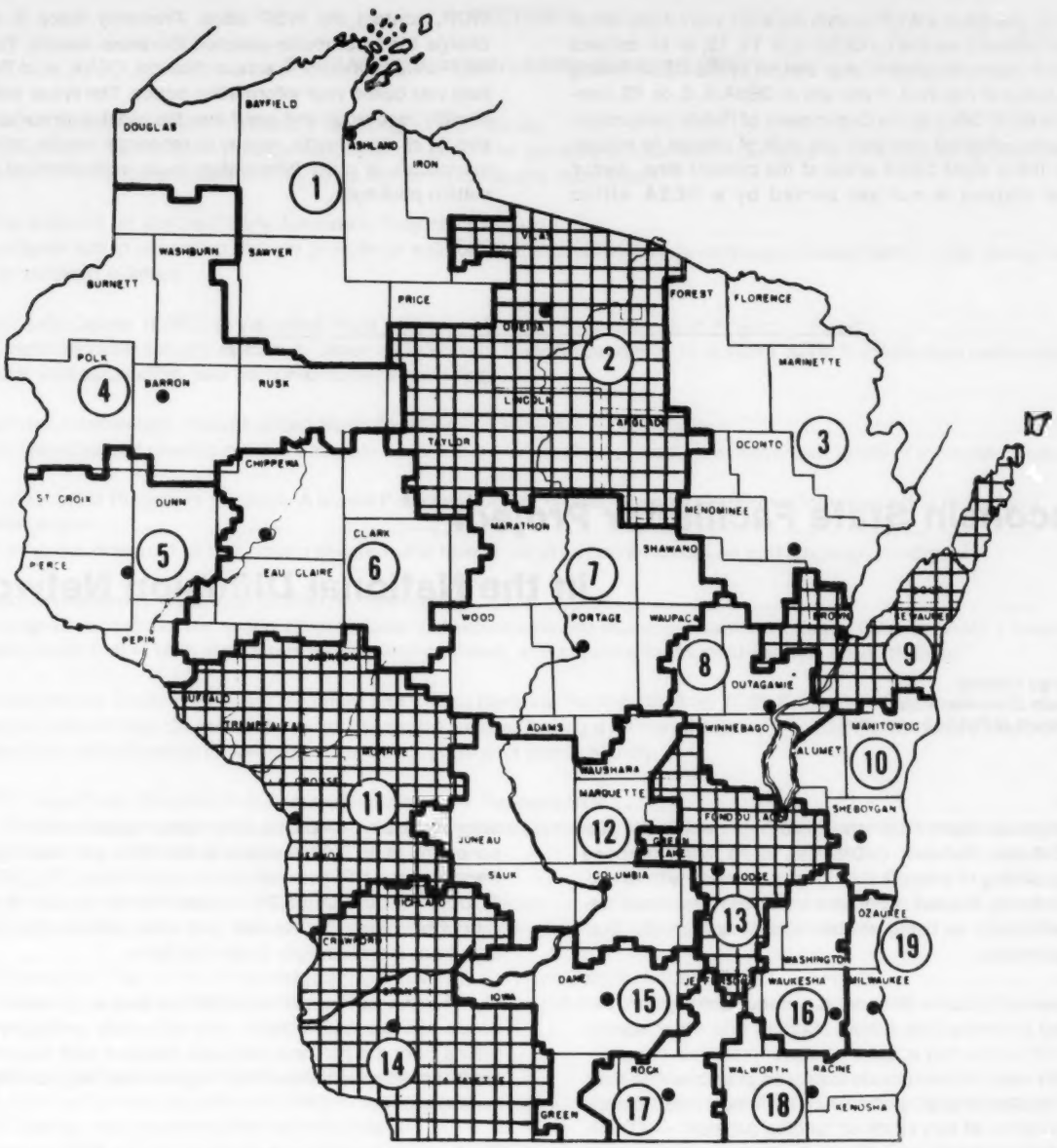
Abstracts of ERIC documents and journal articles are retrieved during a WDP computer search. The abstracts are printed at the Madison Academic Computing Center and are included in the WDP information package. RIE documents are available from ERIC microfiche collections. There are 16 libraries in Wisconsin which have an ERIC microfiche collection. Information on borrowing ERIC microfiche or purchasing ERIC microfiche and hard copy is included in the WDP information package.

Three other national data bases that WDP can search are particularly relevant to the field of special education. They include: Exceptional Child Education Resources, National Information Center for Special Education Materials (NICSEM/NIMIS), and Psychological Abstracts. Exceptional Child Education Resources include more than 28,000 abstracts of published and unpublished literature on the education of handicapped and gifted children. These abstracts are also prepared at the Council for Exceptional Children and follow the same format of an ERIC abstract.

NICSEM/NIMIS contains descriptions of media and devices for use with handicapped children such as guides and manuals, testing instruments, toys, films, and cassettes. The NICSEM printouts included in a WDP package give bibliographic information, price, an explanation of the type of material, etc. The items themselves must be ordered from the publisher, producer, or possibly borrowed from an SEIMC or library.

Psychological Abstracts include over 260,000 citations from the world's literature in psychology and related fields in the behavioral sciences. Over 900 periodicals and 1,500 books, technical reports, and monographs are scanned for suitable entries each year.

The Wisconsin Dissemination Project is designed to be a decentralized statewide education dissemination system. WDP is funded by the National Institute of Education under a State Capacity Building Grant. During the next 5 years, we will be building the capacity to deliver information, resources, and assistance to teachers and administrators in all areas of Wisconsin. A major means for linking educators to these services is through the Cooperative Educational Service Agencies (CESA). As illustrated by the map in Figure 1, five CESA are presently serving as WDP retrieval centers for their school districts. They include CESA 2-Minocqua, 9-Green Bay, 11-La Crosse, 13-Waupun, and 14-Fennimore. Personnel in these CESA areas, called linking agents, have been trained to do computer-assisted searches of ERIC and to use other information and library resources to answer requests. Each of the CESA retrieval centers has a portable microfiche reader available for loan to school districts and a reader/printer to make hard copy prints of microfiche. The CESA van/delivery systems are used to deliver information packages, ERIC microfiche, and other materials to requestors.



CESA 2

Jim Warnecke, Linker
P.O. Box 168
Minocqua, WI 54568
(715) 356-9461

CESA 9

Debby Loofboro, Linker
1927 Main Street
Green Bay, WI 54301
(414) 497-3755

CESA 11

Marilyn Van Wyk, Linker
LaCrosse Co. Court House
LaCrosse, WI 54601
(608) 785-9364

CESA 13

Dwayne Schmaltz
CESA Administrator
908 S. Main Street
Waupun, WI 53963
(414) 324-4461

CESA 14

Diane Hutchison, Linker
Beatrice Orrick, Linker
1190 Fourth Street
Fennimore, WI 53809
(608) 822-6114

WDP Office

Loretta Harmatuck
WDP Coordinator
Department of Public Instruction
126 Langdon Street
Madison, WI 53702
(608) 266-2127
(608) 266-3108

Figure 1—Wisconsin Dissemination Project Retrieval Centers and linking agents.

How can you have a WDP search done for you? If you are in a school district served by CESA 2, 9, 11, 13, or 14, contact the WDP representative in your district or the CESA linking agent listed in Figure 2. If you are in CESA 3, 8, or 15, contact the WDP Office at the Department of Public Instruction. Computer-assisted searches are free of charge to educators in these eight CESA areas at the present time. If your school district is not yet served by a CESA within WDP, contact the WDP office. Presently there is a $10 charge for a computer-assisted literature search. Trained WDP linkers whether in school districts, CESA, or at DPI will help you define your information needs. The linker will then identify resources and send you the most appropriate abstracts of documents, names of resource people, selected microfiche, or other information in an individualized information package.

Wisconsin State Facilitator Project in the National Diffusion Network

By George Glaerud
Wisconsin State Facilitator
Department of Public Instruction

The Wisconsin State Facilitator (WSF) project in the National Diffusion Network (NDN) has as its major purpose the acquainting of schools throughout the state with exemplary, federally funded programs which have received national validation as being student effective, cost effective, and exportable.

The National Diffusion Network is a nationwide system established to insure that school districts and other educational institutions may acquire whatever materials or assistance they need to incorporate improved practices into their current educational programs. The NDN operates through the interaction of two kinds of funding projects — Developer/Demonstrators and State Facilitators. Developer/Demonstrators (D/Ds) are schools and staff who were involved in the original development of the exemplary educational programs found in the National Diffusion Network. A D/D designation means that the project staff may receive federal funds under the NDN specifically to provide materials, training, and technical assistance to interested adopters.. The number of D/D at a given time is determined primarily by the available resources. Of the over 200 D/D programs in the National Diffusion Network, 41 deal with special education/learning disabilities, mainstreaming programs.

The second funded component of the NDN is the State Facilitator (SF), the primary link between Wisconsin educators with needs and D/D staff. Now all states have one or more State Facilitators. State Facilitators first create awareness within their state or region of the existing exemplary programs — particularly those funded as D/D. Descriptions of all D/D projects in the NDN are found in the Department of Public Instruction publication, FOCUS ON EDUCATIONAL SUCCESS; copies of which are found in all school buildings, both public and nonpublic, or are available from the Wisconsin State Facilitator.

The major emphasis of the WSF project is to match the needs of Wisconsin schools with nationally available programs from the National Diffusion Network and to provide adoption/adaption assistance required for program implementation.

The types of assistance available from the WSF project include awareness conferences, staff training sessions, monitoring, follow up, and evaluation of the program. Limited financial assistance in the form of travel and training costs is possible within the limitations of the project funding for schools whose adoption/adaption proposals are approved.

Wisconsin schools are urged to "Avoid reinventing the wheel, but using proven educational programs that work."

Any school in Wisconsin with an identified need in the area of special education should feel free to contact:

Wisconsin State Facilitator
Wisconsin Diffusion Network
126 Langdon Street
Madison, WI 53702
Phone (608) 266-2101

SECTION 8

SPECIAL EDUCATION/LEARNING DISABILITIES*

ACTIVE: All Children Totally InVolved Exercising — New Jersey 8-5
A diagnostic/prescriptive physical education program that provides teachers with the skills, strategies, and attitudes necessary to initiate a physical-activity program for handicapped individuals.*

Central Institute for the Deaf Early Education Project - Missouri 4-8
A project aimed at helping parents provide an environment that will stimulate language development in their young hearing-impaired children.

Child Study Center (CSC): A Validated Pupil Personnel Services Demonstration Project — Florida 8-6
A pupil services delivery system to assist children with learning problems to achieve gains in intellectual performance, basic skill acquisition, and personal/social functioning.

Classroom Intervention: Individualized Basic Skill Reading Program — Washington 7-16
An individualized reading program intended to increase the basic skill reading-achievement levels of inner-city students.

Communication Programs [formerly A Model Preschool Center for Handicapped Children: Communication Programs] — Washington 4-11
A program designed to help young children who have a variety of communication and language handicaps.

the Communications Workshop (CWS) — New Jersey 8-7
Designed to improve the quality of basic skills instruction afforded learning-disabled students, CWS provides a balanced curriculum that is both structured and student-centered, and provides for student-teacher accountability.

Comprehensive Training Program for Infant and Young Cerebral Palsied Children (C.P. Project) — Wisconsin 4-13
A program serving children three years of age and younger having a primary disability of moderate-to-severe neuro-motor handicap with physical impairment severe enough to limit motor activity.

COPE: Cognitively Oriented Pre-Primary Experience — Pennsylvania 4-14
A comprehensive preprimary curriculum and management system that provides for individualized developmental growth and learning of basic readiness skills.

Dale Avenue Early Childhood Education Project — New Jersey 4-15
A performance-objective, individualized curriculum for pre-kindergarten through third grade.

Developmental Play (DP): A Validated Pupil Personnel Services Demonstration Project — Florida 4-16
A training program for adults who wish to work with young children in a relationship-focused activity-based intervention program.

Diagnostic Prescriptive Arithmetic (DPA) — New York 7-22
A basic arithmetic program for children operating at an instructional level from grades 1-6 with emphasis on developing, modeling, and mastering the basic concepts.

Diversified Educational Experiences Program (DEEP) — Kansas 1-5
A new method of organizing and managing an academic classroom.

Early Childhood Preventive Curriculum (ECPC) — Florida 7-24
A program developing in high-risk first-grade students the perceptual, cognitive, and language skills that they need to respond successfully to begining reading instruction.

Early Prevention of School Failure — Illinois 4-18
A program designed to prevent school failure through early identification and remediation of developmental learning deficiencies in children ages 4-6 that would adversely affect their school performance.

Engineered Classroom for Students Who Are Both Educably Mentally Handicapped and Behaviorally Maladjusted — Nebraska 8-8
A diagnostic teaching program that provides individualized instruction and engineering of time and behavior for handicapped students.

*Projects with multiple emphases may be listed under more than one section.

Project ERIN: Early Recognition Intervention Network — Massachusetts 8-9
Coordinated training programs and service delivery systems aimed at harnessing the learning environment/materials/adult intervention resources to teach young children with a range of special needs.

The Fail Save Continuum of Services for Learning Disabled Students — New Mexico 8-10
A continuum of special education services for learning-disabled students.

Family-Oriented Special Education Preschool Program [formerly UNISTAPS] — Minnesota 8-11
A program serving moderately and severely handicapped preschoolers (0 to 4 or 5 years of age) and their families, with a variety of service options being provided by a multidisciplinary team.

Family Oriented Structured Preschool Activity (Seton Hall Program) — Minnesota 4-20
A program that prepares the parent to be the child's first and most significant teacher.

FAST: Functional Analysis Systems Training — Michigan 6-8
A developmental diagnostic/prescriptive teaching system for mainstreaming handicapped students.

HOSTS: Help One Student To Succeed — Washington 7-34
A diagnostic/prescriptive/tutorial approach to basic reading skills.

project INSTRUCT: Instructional System for Teaching Reading Using Continuous-Progress Technology — Missouri .. 7-38
A word-attack and spelling system, accompanied by direct teaching methods for kindergarten through third grade students.

Learncycle: Responsive Teaching — New Jersey 6-9
An intensive teacher training program developing flexible, effective skills for managing and teaching mainstreamed or "high risk" students.

Project Learning Disabilities: Early Identification and Intervention — Louisiana 8-12
An early identification program for students with learning disabilities.

Learning to Read by Reading — California 7-42
A unique method of teaching reading to sub-par achievers at upper-elementary through junior college levels who have failed to progress with the use of conventional methods and materials.

MECCA: Make Every Child Capable of Achieving — Connecticut 4-25
An intervention program for vulnerable children (with a deficit in a skill area) in regular classes in their first years of schooling.

Modification of Children's Oral Language — California 8-13
A special program for training staff to work with students having language disabilities.

Northwest Special Education (NWSE) — North Dakota 8-14
A systematic way of training classroom teachers to focus on specific learning disability (SLD) students.

Oklahoma Child Service Demonstration Center for Secondary LD Students — Oklahoma 8-15
An individualized diagnostic-prescriptive teaching intervention system that has proven highly successful with learning-disabled adolescents.

PA: Project Advocate — Northwestern Illinois Association — Illinois 8-16
A consistent, data-based, intensive learning environment for students.

Parent-Child Early Education Program (Saturday School) — Missouri 4-29
A program available to all preschool children, birth through four, structured to increase each child's chances for success in school.

Parent Readiness Education Project (PREP) — Michigan 4-30
An early-intervention project for academically high-risk preschool children, in which parents attend classes to learn to become effective change agents for their own children; and high school students learn preparenting skills while working with children.

PEECH: Precise Early Education for Children with Handicaps — Illinois 8-17
An individualized educational program designed to enhance the development of preschool handicapped children while involving family members in the educational process.

Perception+ [formerly project SEE] — New Jersey 4-31
A prerequisite to any formal learning discipline.

Pilot Project Utilizing Supportive Personnel Using Behavior Modification Techniques with Articulatory Disordered Children — Iowa 8-18
A model for expanding speech therapy delivery through training of paraprofessionals as communication aides.

Positive Alternatives to Student Suspensions (PASS): A Validated Pupil Personnel Services Demonstration Project — Florida 6-11
A program that provides intervention strategies designed to prevent or minimize nonproductive social behavior of secondary students.

Positive Attitude Toward Learning (PATL) — Illinois 6-12
A performance-based inservice training program designed to improve student attitudes toward school by strengthening the consistency of teacher behavior.

Program for Children with Down's Syndrome [formerly A Model Preschool Center for Handicapped Children: Down's Syndrome Program] — Washington 4-34
A program designed to accelerate and maintain developmental gains of children with Down's Syndrome; to give help and training to their parents; to develop a transportable model; and to provide an exemplary demonstration program.

RE-ED School of Kentucky — Kentucky 8-19
A short-term plan for the reeducation of emotionally disturbed/behaviorally disordered children.

Remediation of Learning Deficits Through Precision Teaching: The Sacajawea Plan — Montana 8-20
A precision teaching model designed to remediate and build basic tools skills through use of these components: (1) screening, (2) identification, (3) remediation, (4) continuous measurement, and (5) data-based decisions.

The Rutland Center — Developmental Therapy Model for Treating Emotionally Disturbed Children — Georgia 8-21
A community-based psychoeducational facility that offers a developmental curriculum to severely emotionally disturbed or autistic children from birth to 16 years, their parents, and teachers.

School Volunteer Development Project — Florida 7-60
A delivery system of school volunteer services that directly addresses critical learner needs for grades 2-6 in reading and mathematics.

Project SHARE: Sharing High Yield Accountability with Resource Educators — Minnesota 8-22
An instructional process for remediation of basic skills in learning-disabled students in mainstream education.

Project SKI*HI — Utah 4-38
A statewide program for identification and language facilitation for hearing-handicapped children through home management, ages birth to six.

Project Success for the SLD Child — Nebraska 8-23
A prescriptive program and classroom delivery system for K-9 pupils with specific language disabilities.

Project Success: Handicapped — Washington 8-24
Low-cost academic and self-management programs for handicapped elementary school students.

The Teaching Research Infant and Child Center Classroom for Moderately and Severely Handicapped Children — Oregon 8-25
An individualized skills instruction program for moderately to severely handicapped children.

Some Thoughts for Incorporating Child Find on the Local District Level Utilizing School Census Procedures

By David Moscinski
Child Find Coordinator
Freedom Area School District

The purpose of this paper is to describe what the author feels is an efficient and comprehensive method of continuing Child Find on the local level in future years. The ideas contained in it are based on the Census/Child Find procedure which has been utilized in part in the Freedom Area School District for the past 2 years. They are offered for your consideration with the hope that they will be helpful in planning future Child Find programming.

The proposal for incorporating Child Find on the local level is basically a very simple one. It is based on the assumption that the local district utilizes some form of door-to-door procedure for taking their annual census. Many school districts in the state do take the annual census in this fashion. However, a sizeable number do not. For this reason the second part of this paper will describe a plan for developing a modified door-to-door census taking procedure for those districts which do not currently use this method.

In districts where the census is currently taken on a door-to-door basis each year, Child Find becomes a simple added step to this procedure. Adding Child Find to a door-to-door census guarantees that appropriate information gets into the homes of every parent in the district. Parents are free to read Child Find information in the privacy of their own home. If they have questions, they can contact the Child Find Coordinator whose name and number is listed as a part of the information. If parents so wish, they can make a request for screening utilizing the Screening Request form they have received as part of the Child Find information. Since every house is contacted in a door-to-door census, Child Find information enters every household.

This proposed method has as its basis a Child Find packet which is prepared beforehand for distribution by the census takers. The packet contains three different pieces of information. First of all, there is a cover letter describing the Child Find process in detail. Information in this letter is drawn from the various pamphlets and brochures that have been provided by the State Child Find Project. Secondly, the packet contains a copy of the screening brochure which has been provided from the State Child Find Project. This brochure may be modified somewhat, but the basic information contained in it should be kept essentially the same. Thirdly, the packet contains a Request for Screening card which the parents may fill out if they desire a screening for their child.

Once this Child Find packet is assembled, it is then distributed to each home in the district by the census takers when they make their annual visit. If, as a result of having received the Child Find packet, a parent wishes to request a screening for their child, they mail the Request for Screening form to the school. Follow-up action is then taken by the Child Find Coordinator or the person who is in charge of the screening process. New families in the district who have at least one child of school age may receive the Child Find packet when they register their child for school.

Although this proposal is an admittedly simplistic one, it does work. It is an effective way of incorporating Child Find on a local level for those districts which utilize a door-to-door census taking procedure. For those districts that do not use this method of census taking, a rationale and description for developing one is contained in the second part of this paper.

Plan for Developing a Door-to-Door Census Taking Procedure

Rationale

State law currently requires that each district conduct an annual census. The law does not, however, specify how this census is to be taken. Local districts consequently utilize many different methods for taking their census. Some do it on a phone basis, others do it by mail. Some districts utilize hospital birth records and credit bureau checks. Some have computerized records and still others employ a combination of these and other methods. However, unless a district does their annual census on a door-to-door basis, they cannot be certain of the accuracy of their figures. The mobility factor is so great in our society today that unless each home is contacted on an individual basis each year, there will be a certain percentage of error in the census figures.

The error will most likely be greatest in the Preschool (0 to 4) populations. A check on district census records will show that there is a good deal of fluctuation between the newborn, 1- and 2-year-old populations from year to year. Because of the declining enrollments facing districts today, it becomes extremely important that the preschool age counts be exact. Prediction for future building and teacher needs is based, in great part, on the future numbers of preschoolers. A door-to-door census count is the best method of guaranteeing accuracy in these counts. Therefore, the first point in the rationale justifying a door-to-door

census procedure is that it is the most accurate method of taking a census. It particularly guarantees the best accuracy possible in the crucial count involving preschool population.

A second major point in justifying a door-to-door census is the federal law which requires school district participation in a Child Find effort. As described in the first part of the article, incorporating Child Find into a door-to-door census taking procedure appears to be the simplest, yet most effective method of getting Child Find information to each family in the school district. By tying census and Child Find together, two legally mandated programs work together. Long term cost savings should result from this.

Plan

There are numerous ways in which a school district may establish a door-to-door census taking procedure. PTA volunteers may work under the direction of a paid census coordinator. A number of census takers may be paid on a per capita basis for each family name they take. In smaller school districts, a single census taker may be hired to conduct the census alone. The manner in which the door-to-door census is taken depends greatly on the geographical size and the population density of the district. However, careful planning can establish an acceptable door-to-door census procedure no matter what the size of the district. As an example, the Madison School District successfully conducted a door-to-door census procedure and "Child Find" project in the mid 1960's. The results of the Madison project are described in detail in the Spring, 1975 issue of the BUREAU MEMORANDUM.

The plan offered for consideration here is based on the Census/Child Find procedure which is currently utilized in the Freedom Area School District. This is a rural school district located northeast of Appleton. The district covers 76 square miles and has a population density of approximately 70 to 75 persons per square mile. Its total enrollment of 1250 places it at approximately the 50th percentile when compared to other districts in Wisconsin. The census taker is also the Child Find Coordinator and is employed as a professional within the school district during the regular school year. Additional contract time is provided during the school year to cover follow-up Child Find activities which are done after normal school hours. The census is conducted after the close of the regular school year, approximately June 3, and is completed before July 15. Informational Child Find visits are conducted during the census itself and also after school hours during the regular school year.

The Census/Child Find activities are conducted in the following manner. At the beginning of May, census forms and Child Find packets are sent home from each school building with the youngest child in the family. The completed census sheets are then returned to school and collected by the Census/Child Find Coordinator. Any requests for screening returned at this time are noted and appropriate action is taken. Once the census sheets are returned, they are arranged in order according to the roads on which the families reside. One of the townships in the district has town numbers for each house which makes the arranging process much easier. For those townships in which there are no numbers, the families are asked to list the crossroads on either side of their home. Subdivisions in the district usually have house numbers which, again, makes the arranging process much easier.

Once the census sheets have been arranged according to roads, actual road work then begins for the census. Wherever an up-to-date census sheet exists for a home, no census stop needs to be made. In rural areas, homes are usually identified by names on the mailboxes. The exception to this, however, is homes where there are preschoolers living. In this case, a follow-up Child Find visit is made. In this visit, the parents are asked if they have received Child Find information. When the parents indicate they have received the Child Find packet, they are then asked if they have any questions about it. In some instances, the packet may have been lost with the child taking the information home. In these cases, a Child Find packet is given to the parents. If parents do have questions about information from the Child Find packet relative to a preschooler, they are encouraged to fill out the Request for Screening form. It is stressed to them that the information from the screening is confidential and the screening itself is not a referral. Action is taken on the request for screening as soon as school begins again in the fall. If the parents have no questions about the Child Find packet, they are thanked for their time and the census taker proceeds to the next house.

As mentioned previously, except in the case of preschoolers, no stop needs to be made at homes where the census taker has an up-to-date census sheet. Previously completed census sheets account for approximately 35% of the homes in the Freedom School District. Time is thereby saved by not having to make stops at these homes. Where no up-to-date census sheet exists for a home, a census stop is then made. The pertinent information is gained from the individual in the household and a Child Find packet is given to the parent. Time for a Child Find follow-up contact, if necessary, is available after school hours during the regular school year. The census taker repeats this procedure for every road and subdivision in the school district. Upon completion of the census, the data are tabulated and forwarded to Madison. A record is kept of Child Find visits made during the census. Special note is taken of the follow-up contacts which will need to be made after regular school hours during the coming school year.

This, then, describes a Census/Child Find procedure which is currently used in one school district. This method has worked effectively in the school district and has resulted in what is felt to be an appropriate number of requests for screening since its inception. The method is workable and has identified children with exceptional educational needs who have not been in school and has contributed to their receiving appropriate educational assistance. As mentioned previously, the presentation of this model is meant to serve as a point of discussion and reference for those school districts who wish to develop a combined Census/Child Find procedure of their own.

"Grandma, Can You Help Me?"

By M. Jean Rusch
Teacher of the Physically Handicapped
James Madison School, Sheboygan

"Grandma, can you help me?" These words have a familiar ring in the classrooms of James Madison School in Sheboygan. This year, under the directorship of Dorothy Minster, eleven foster grandparents spend 4 hours daily in regular and special classes. They work in a one-to-one relationship, with the supervision of the classroom teacher, helping individual children with reading, math, writing, and spelling.

The extra time, attention, and love they give to children often makes the all-important difference between success and failure. Love starved children, too common in today's society, literally blossom and bloom under their gentle approval and warm smiles. Grandparents are able, with a lifetime of experience, maturity, and stability, to establish unique and special relationships with children. They transmit feelings of security, trust, self approval, and confidence to the small person beside them.

Ellie, a waif-like child of 6 was functioning at a trainable level. She was nonverbal except for a few simple words. The mutual feeling that transpired between Ellie and her newly assigned grandmother could be described as none other than "love at first sight." "Ba ma" became the most important word in her fast growing vocabulary. There wasn't anything Ellie wouldn't do for "Ba ma." Within a 6-month period that "anything" included reading, writing, and beginning to talk in sentences of four to six words. While the classroom teacher provided the programming for Ellie's phenomenal progress, it was "Ba ma" who provided the motivation in the form of love.

Figure 1—Grandma Elvira and Bobby in the Family Living Center.

Roy, partially sighted and physically handicapped, needed total one-to-one help in order to operate his print enlarger. He also needed a "recorder" to write the answers for his math, spelling, and reading assignments. His teacher was able to give him 20 to 30 minutes of individual time daily. Needless to say his academic progress had been slow, placing him farther behind his grade level with each passing year. After a foster grandmother entered his life, he was able to receive 2 hours of individual help per day. Overnight, his work output became four times greater and his stepped up progress was reflected in higher achievement scores at the end of the year.

The Foster Grandparent Program is federally funded under Title VI, Part B of the Older American Act of 1965. Its purpose is to provide part time volunteer opportunities for lower income persons age 60 and over and to supply supportive service to children having special needs. Objectives of the Foster Grandparent Program are as follows:

1. To establish a useful way for older adults to contribute to their community in the retirement years and to enjoy the self-respect and satisfactions that come from being needed and serving others.

2. Provide a source of individual attention and personalized care for children with special needs.

3. Improve the attitudes of society including attitudes of older persons toward old age.

4. Demonstrate the willingness and capacity of retired persons to participate reliably in community service roles on a part time basis.

5. Promote new patterns of cooperation between professional and nonprofessional personnel.

(From Federal Guidelines on Foster Grandparents)

Figure 2—Grandma Evelyn with Lisa and Jim (back to camera). The children are mainstreamed into a primary open classroom setting.

The Foster Grandparent Program is sponsored by ACTION, a federal agency that merges all federal volunteer programs and is dedicated to the philosophy of helping people to help themselves. The program serves children in pediatric wards; homes for dependent and deprived children; and institutional settings. The Sheboygan program, now in its fifth year of operation, is unique in that it is the first such program to function in a public school setting in the state of Wisconsin.

Administrators, teachers, parents, and children are all enthusiastic about the Foster Grandparent Program at James Madison School. The foster grandparents also derive a great deal of satisfaction from their contacts with the children and staff. They are welcomed with genuine smiles and warm helloes as they come to work each morning. When asked about how they like their jobs they reply, "I enjoy being here. This school is such a friendly place to work in. I love children and it's fun helping them."

Federal programs are often the object of public criticism perhaps because their goals are difficult to visualize or measure. This cannot be said of foster grandparents, however. In the Sheboygan area the program has received nothing but praise from civic groups, parents groups, and teacher organizations. The Foster Grandparent Program is a shining example of a federal program with humanitarian goals that is benefiting two very important groups of Americans.

Flowers Are Not in Your IEP Young Man

Teacher, the young man said, I found this flower over the weekend and I want to know what made it grow.

Look young man, you're in special education. You must have an IEP, it's the law you see.

And flowers are not in your IEP, young man!

You have short term objectives in math and reading, young man.

You have long range goals in self help and getting along with others.

But flowers are not in your IEP, young man!

But teacher, the young man said, I really want to know what makes the flowers grow.

Look young man, your mother and father and the principal and I wrote your IEP and then we signed it, that's the law, you see.

And flowers are not in your IEP, young man!

Your IEP has an evaluation component, young man, it's the law you see. And I want you to reach your objectives and attain your goals.

There's no time for anything else, and besides. . . .

flowers are not in your IEP, young man!

Please teacher, the young man said, I'd rather learn about flowers than math or reading.

Ok, young man, if you insist, but this will be a significant change in your IEP and your parents will have to agree, it's the law you see.

A month has passed, a conference was held, the IEP was revised, procedural safeguards were observed, and all the necessary paperwork completed, it's the law you see.

And flowers are now in your IEP, young man.

But teacher, the young man said, my flower is dead and I found a frog over the weekend and now I want to know what made it grow.

Look young man, your mother and father and the principal and I revised your IEP and then we signed it, that's the law you see.

And flowers are now in your IEP.

You have short term objectives in math, reading, and *flowers,* young man.

You have long range goals in self help and getting along with others.

But frogs are not in your IEP, young man!

By Gary J. Makuch
Pennsylvania Department of Education

New Laws Open the Field to the Handicapped

By Julian U. Stein
Consultant for Programs for the Handicapped
American Alliance for Health, Physical Education, and Recreation

Physical education should be a major part of each handicapped child's education, according to integral but often overlooked or neglected provisions in both the Education for all Handicapped Children Act Public Law (P.L.) 94-142 and Section 504 of the Rehabilitation Act of 1973 (P.L. 93-112). In fact, physical education is the only curricular area specifically delineated in both of these legislative mandates which ensure a free appropriate education to every handicapped child.

The definition of special education in P.L. 94-142 states, "'special education' means specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, *instruction in physical education,* home instruction, and instruction in hospitals and institutions" (emphasis added).[1] The regulations for Section 504 also deal specifically with physical education and athletics, employing identical language for preschool, elementary, and secondary as well as post-secondary education:

> In providing physical education courses and athletics and similar programs and activities to any of its students, a recipient to which this subpart applies may not discriminate on the basis of handicap. A recipient that offers physical education courses or that operates or sponsors interscholastic (intercollegiate) club or intramural athletics shall provide to qualified handicapped students an equal opportunity for participation in these activities.
>
> A recipient may offer to handicapped students physical education and athletic activities that are separate or different from those offered to nonhandicapped students only if separation or differentiation is consistent with the requirements of [sections dealing with educational settings] and only if no qualified handicapped student is denied the opportunity to compete for teams or to participate in courses that are not separate or different.[2]

Long-Standing Congressional Concern

This emphasis on physical education in both P.L. 94-142 and Section 504 reflects congressional intent as stated in House of Representatives Report No. 94-332:

> The committee expects the commissioner of education to take whatever action is necessary to assure that physical education services are available to all handicapped children and has specifically included physical education within the definition of special education to make clear that the committee expects such services, specially designed where necessary, to be provided as an integral part of the educational program of every handicapped child.[3]

This report continued:

> Special education as set forth in the committee bill includes instruction in physical education, which is provided as a matter of course to all nonhandicapped children enrolled in public elementary and secondary schools. The committee is concerned that although these services are available to and required of all children in our school systems, they are often veiwed as a luxury for handicapped children.[4]

These positions reinforce long-standing congressional concern about the lack of emphasis on physical education in programs and activities designed to benefit handicapped young people. In the Mental Retardation and Mental Health Facilities Construction Act of 1968 (P.L. 90-170), specialized sections were enacted under Title V, Training of Physical Educators and Recreation Personnel for Mentally Retarded and Other Handicapped Children. Title V provided both authorizations and appropriations for training, research, and demonstration projects related to physical education/adapted physical education, and recreation/therapeutic recreation involving impaired, disabled, and handicapped participants. Since 1968, both authorizations and appropriations for projects in these areas have gradually increased through the Divisions of Personnel Preparation and of Innovation and Development in the Bureau of Education for the Handicapped (BEH).

On the other hand, support for direct service in these areas has been minimal—despite increased interest which has been stimulated in part by projects sponsored and supported by BEH, as well as through activities of various professional and volunteer organizations and by pressure from personnel in the field. While some projects and activities have been supported through Elementary and Secondary Education Act Title I, III, and VI projects, no specific inclusions or line items have provided direct and specific support for physical education and recreation through other divisions in BEH.

These factors all contributed to increased congressional interest in providing support and assistance for physical education, recreation, sports, and related activities for the handicapped. The evidence from many sources strongly attests that active participation in these activities promotes better health, higher quality lives, and personal satisfaction among impaired, disabled, and handicapped persons, thus providing further justification for their inclusion and primacy in these most recent mandates.

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A Common Baseline

Because virtually every individual defines physical education differently, it is vital for personnel who are responsible for implementing these mandates to operate from a common baseline. Such a baseline is provided in the rules and regulations for P.L. 94-142, which define physical education as the development of

-Physical and motor fitness.
-Fundamental motor skills and patterns; and
-Skills in aquatics, dance, and individual and group games and sports (including intramural and lifetime sports).
-The term includes special physical education, adapted physical education, movement education, and motor development.[6]

The framework makes it clear that to be in compliance, educators must emphasize actual, organized instruction in physical education. Free play, recess, roll-out-the-ball programs, and other noninstructional approaches are consistent with neither the intent nor the letter of the laws themselves nor their rules and regulations. Using physical education activities to attain general or specific social, intellectual, emotional, cognitive, or affective goals *per se* is not to be considered physical education under either the statute or the regulations. Physical education is considered a legitimate need with its own goals and objectives and not simply a method or means to an end. Terms in the law and in the regulations such as "instruction in physical education" and "development of physical and motor fitness," coupled with congressional testimony make it extremely clear that physical education is to be included so that children can reach specific physical, motor, psychomotor, and health goals.

Certainly, we want to encourage extensive use of physical education, recreation, and sports as the means for achieving such valuable ends as enhanced self-confidence and self-esteem. However, these goals should be in addition to, not in place of, planning and implementing physical education programs and recreational activities for their own specific, unique, and necessary objectives. These same principles and cautions must be exercised in distinguishing between physical therapy and physical education.

All of the major provisions of these two laws pertaining to education in general must be applied to physical education as well, including individualized education programs and least restrictive alternatives. In many ways these latest special education mandates are consistent with and reinforce philosophies of adapted physical education that have been advocated for over a quarter of a century. The generally accepted definition of adapted physical education was developed in 1952 by a special committee of the American Association (now Alliance) for Health, Physical Education, and Recreation (AAHPER) and reaffirmed in 1971 by national representatives of the profession as part of a special project conducted by AAHPER and supported by BEH. Adapted physical education consists of

> a diversified program of developmental activities, games, sports, and rhythms suited to the interests, capacities, and limitations of students with disabilities who may not safely or successfully engage in unrestricted participation in these vigorous activities of the general physical education program.[6]

Meeting Individual Needs

Careful analysis of this definition reveals attention to fundamental considerations of both P.L. 94-142 and Section 504. The definition emphasizes the interests, capacities, and limitations of individual students. No mention is made of specific handicapping conditions so that determination of whether an individual can safely or successfully take part in regular programs and activities is based on his unique performance, proficiencies, and functional abilities. Adaptations permit individualized annual goals, objectives, motivational techniques, activities, methods, facilities, equipment, and devices, and administrative/organizational structures.

For at least 10 years this definition of adapted physical education has been interpreted to imply a continuum of alternative placement opportunities for handicapped children. Specifically, regular class placement has been advocated for individuals who can take part in regular activities safely, successfully, and with personal satisfaction. For other individuals, a halfway house or intermediate placement has been advocated to assist in building confidence, gaining experience, and developing skills. Special placement has been advocated for individuals with severe, profound, and multiply handicapping conditions who require special attention through long-range opportunities and experiences in specially designed activities.[7]

This approach is similar to the Cascade of Special Education services developed in and advocated since the early 1960s. It is also consistent with the P.L. 94-142 regulations dealing with the continuum of alternative placement,[8] which mandates that alternative placements must be made available to meet the needs of handicapped children. Because instruction in physical education is a defined part of special education, alternative placements must include opportunities for instruction in regular classes, special classes, special schools, home instruction, and instruction in hospitals and institutions, or regular classes with supplementary services, such as resource room or itinerant instruction.

School personnel involved in educating handicapped youths must recognize that programs which are removed from regular physical education environments can take place only when the nature or severity of the handicapping condition is such that success in regular classes cannot be achieved safely or satisfactorily with use of supplementary aids and services. Handicapped young people, including those in public or private institutions or in other care facilities, must be given maximum appropriate instruction in physical education programs and activities with their peers who are not handicapped.

Despite this philosophical and conceptual framework and despite legislative mandates, too many adapted physical education programs continue to be governed by policies and affiliated with the same hardened categories that have resulted in special education litigation and legislation during the last 6 or 7 years. In the past, too many physical educators like special educators, have followed the process of *label* a child, *place* that child, and then *program* for the class. Often these programs had little relevance to the real needs of the individuals.

Now the process is to assess each child's needs and develop the program for each child based on these identified needs. An individual student's program is developed after the educator has determined appropriate placement for each activity in which the child is to participate. The regulations for P.L. 94-142 clearly stipulate the necessity for individualized tailoring of the educational programs:

> Physical education services, specially designed if necessary, must be made available to every handicapped child receiving a free appropriate public education.
>
> Each handicapped child must be afforded the opportunity to participate in the regular physical education program available to nonhandicapped children unless: (1) The child is enrolled full time in a separate facility; or (2) the child needs specially designed physical education, as prescribed in the child's individualized education program.
>
> If specially designed physical education is prescribed in a child's individual education program, the public agency responsible for the education of that child shall provide the services directly, or make arrangements for it to be provided through other public or private programs.
>
> The public agency responsible for education of a handicapped child who is enrolled in a separate facility shall insure that the child receives appropriate physical education services [as delineated above][9]

Designing Special Programs

Specially designed physical education programs, though not directly addressed in P.L. 94-142 rules and regulations, can be implemented in a regular class setting when this is the most normal setting appropriate for a particular handicapped child at a given time. This can be accomplished in many ways, including the use of

- A buddy system which pairs a handicapped child with an ablebodied partner for specific activities.
- Peer tutoring,
- Students as squad leaders,
- Circuit or station organizational patterns,
- Problem solving, exploratory, and movement education techniques at elementary school levels,
- Elective or selective program patterns at secondary school levels, especially senior high school,
- Flexible or optional unit scheduling, especially at middle, intermediate, and junior high school levels,
- Contract techniques,
- Paraprofessional personnel; aides, volunteers, career education students, practicum or field-work students,
- Team teaching involving regular physical education teachers and adapted physical education teachers or resource specialists,
- Preteaching certain activities to select students with special needs,
- Adapted physical education classes to supplement, not replace, regular physical education classes.

A variety of organizational and administrative patterns can be established to meet the individual physical education needs of students and to fulfill the requirements of individualized education programs. One alternative is combined classes to provide students who need special assistance with opportunities for assignments right along with classmates who don't need special provisions. Each student is assigned activities within the combined class on the basis of physical condition, individual abilities, and personal limitations. Dual classes allow students to carry out a specially designed program by having the opportunity to take part in special physical education classes on certain days and to be in a regular class with their peers on other days. And finally, flexible plans can provide students with opportunities to be assigned special or different activities when they are not able to take part in regular activities or when specially designed physical education activities are prescribed[10]

Interpreting the Regulations

In physical education, individualized instruction through such approaches as specially tailored education programs is crucial to fulfilling the mandates for appropriate educational experiences. Because different individuals are offering different interpretations of the same rules and regulations, actual individualized education programs differ greatly in the amount of physical education they require. Some of these programs contain only the most basic of information; others go into specifics. This is to be expected.

Some individualized education programs, however, do not deal with physical education at all. Such an approach is in conflict with the intent of the law and the specific requirements of the rules and regulations. Since physical education is a defined part of special education, individualized education programs are required by law for children who need specially designed physical education. However, children who need no specially designed physical education program do not require identification of physical education in their individualized education programs. Nevertheless, in either case, individualized planning committees are expected to review motor, physical, movement, and fitness needs of each child to determine whether specially designed physical education programs are required.

Other individualized education programs state that the student is to be scheduled in regular physical education activities throughout the year or for certain units or activities. The generally accepted interpretation has been that those students for whom the regular physical education program is appropriate require no specially designed program or approach; therefore, such activities need not be dealt with in the individualized education programs.

Some states do provide places on individualized education program forms to indicate whether regular or special physical education is appropriate. In this way, no doubt is left that physical fitness, motor proficiency, and other physical education activities have been discussed by the Individualized Planning Committee. If an individualized educational program contains information about specially designed physi-

cal education activities; the student's present level of physical education performance should include an estimation of (1) levels of physical and motor fitness, (2) performance in fundamental motor skills and patterns, and (3) skills in aquatics, dance, individual and group games, and lifetime sports.

Extracurricular Activities

Both P.L. 94-142 and Section 504 require all nonacademic and extracurricular activities and services provided by a public agency to afford handicapped children equal opportunities for participation.[11] Intramural sports are included as a part of the definition of physical education under P.L. 94-142. Athletics are specified in the listing of nonacademic services public agencies must provide and also are included in parts of Section 504 dealing with preschool, elementary, secondary, and post-secondary education. Both interscholastic and extramural athletics — including play days, field days, and sports days — are included in the intent and letter of both mandates.

Section 504 states that separation or differentiation in physical education and athletic activities is permissible only if qualified students are also allowed to compete for regular teams or participate in regular activities.[12] Most handicapped students are able to participate in one or more regular physical education and athletic activities. For example, a student in a wheelchair can participate in a regular archery course, as can a deaf student in a wrestling course.[13]

Section 504 further states that it will not be discriminatory to deny an athletic scholarship to a handicapped person if the handicap makes it impossible for the person to qualify for the award.[14] For example, a student who has a neurological disorder might be denied a varsity football scholarship on the basis of his inability to play football, but a deaf person could not, on the basis of his handicap, be denied a scholarship for the school's diving team. The deaf person could, of course, be denied a scholarship on the basis of comparative diving ability.[15]

Section 504 directly affects many additional aspects of administering and implementing interscholastic and intercollegiate athletic programs. For example, academic eligibility requirements that require students to pass a specified number of subjects, gain so many units, or attain a certain number of Carnegie Units are discriminatory to many mentally retarded students in special education programs. The interscholastic football rule that bars anyone with an artificial hand, arm, or leg is discriminatory as well. In September 1977 interscholastic football, soccer, and wrestling rules were officially revised to read, "Artificial limbs, which in the judgment of the rules-administering officials are no more dangerous to players than the corresponding human limb and do not place an opponent at a disadvantage, may be permitted."

State and local education agencies may not prohibit individuals with one eye or kidney or those who are deaf or epileptic from taking part in general or in specific sports for their own health, welfare, and safety. (It should be noted that a number of cases involving situations such as those described have resulted in different rulings from courts in various parts of the country. While there is no indication of how higher courts might rule on appeal of these decisions, conflicting judgments reveal the complexity of these situations and how unpredictable and inconsistent rulings can be.) Students who want to play wheelchair basketball with a high school or college interscholastic or intercollegiate team must be provided with some type of opportunity to participate in this sport.

Careers in Physical Education

Individuals who want to pursue careers in physical education, recreation, or coaching cannot be denied such opportunities solely on the basis of a handicapping condition. In addition, recipients of federal funds are expected to make reasonable accommodations through changes in requirements and curricula that would tend to discriminate against individuals because of specific impairments or disabilities. All programs must be accessible to these individuals as well.

In fact, accommodations such as providing interpreters for deaf students, eliminating requirements such as surgery for blind medical students, and changing music appreciation requirements for deaf students have been cited as reasonable. Accommodations in physical education, recreation, and coaching curricula might include options or alternatives for certain skills or activity courses, flexible procedures for selecting practice teaching, field work, or practicum sites, and individualized assignments and requirements. No longer can an otherwise-qualified student be kept out of a water-safety-instructor course because of blindness. Of course, these students must meet standards and requirements of the college or university or of an individual department, as long as they are applied and administered equitably and success is not made impossible because of a handicapping condition.

Just as colleges and universities that receive federal funds are prohibited from discriminating against qualified individuals, so too are public school systems regulated in their hiring practices. The same rules and regulations which apply to colleges and universities apply to public schools. As such, an individual cannot be denied a teaching position in physical education or a coaching assignment because he or she is confined to a wheelchair, can't see or hear, or has a past history of emotional difficulties. A number of individuals in wheelchairs teach physical education in public schools throughout the nation; some of these individuals also coach teams at the interscholastic level.

Several court cases have already been settled in favor of plaintiffs who charge that they had been denied teaching positions solely because of their handicapping conditions. In one case, settled under Section 504 and denial of basic due process provisions of the U.S. Constitution, the plaintiff, a blind English teacher, not only received the job but also received credit for seniority accrued from the time the position was initially denied.[16]

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